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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT’S DETAILS** | | | | | | | | | | |
| **Full Name** | |  | | | | **Gender** | | Male  Female | | |
| **Address** | |  | | | | | | | | |
| **Date of Birth** | |  | | | | **Contact Number** | |  | | |
| **GP Surgery** | |  | | | | | | | | |
| **GP’s Name** | |  | | | | | | | | |
| **GP Telephone** | |  | | | | | | | | |
|  | | | | | | | | | | |
| **Please tick this box confirming there are no below contra-indications to exercise** | | | | | | | | | | |
| Cardiomyopathy | | | | | | | Resting systolic BP > 180mmHg/100mmHg | | | |
| Suspected or known aneurysm | | | | | | | Uncontrolled resting tachycardia ≥ 100bpm | | | |
| Febrile illness/Acute systemic illness (e.g. cancers) | | | | | | | Severe breathlessness or dizziness | | | |
| New or uncontrolled arrhythmias | | | | | | | Uncontrolled diabetes | | | |
| Uncontrolled/unstable angina | | | | | | | Unstable or acute heart failure | | | |
| Dementia, Alzheimer’s or severe cognitive impairment (unable to follow simple instructions) | | | | | | | | | | |
|  | | | | | | | | | | |
| **Cautions, recommendations, or special considerations for exercise – please list below** | | | | | | | | | | |
|  | | | | | | | | | | |
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| **MEDICAL HISTORY – please tick all relevant boxes** | | | | | | | | | | |
| Postural Hypotension |  | | Visual Impairment | |  | | OA – please specify | | |  |
| Angina |  | | Hearing Impairment | |  | | RA – please specify | | |  |
| Arrhythmia |  | | Osteoporosis | |  | | Cancer | | |  |
| Asthma/COPD |  | | DM | |  | | MSK – please specify | | |  |
| HTN |  | | MS | |  | | Joint replacement(s)  – please specify | | |  |
| PD |  | | CVA | |  | |
| Other – please specify | | |  | | | | | | | |
|  | | | | | | | | | | |
| **MEDICATION – please list or attach a list to the email when sending the referral form** | | | | | | | | | | |
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| **SOCIAL HISTORY – please tick all relevant boxes** | | | | | | | | | | |
| **Mobility indoors**  **(+/- aid)** | |  | | | **Mobility outdoors**  **(+/- aid)** | | | |  | |
| **Transfers independently** | | Yes  No | | | **Uses stairs** | | | | Yes  No | |
|  | | | | | | | | | | |
| **FALLS HISTORY - please tick all relevant boxes** | | | | | | | | | | |
| **Number of falls in last 12 months** | |  | | | **Fear of falling** | | | | Yes  No | |
| **Previous injuries (inc. fractures)** | |  | | | **Family history of osteoporosis** | | | | Yes  No | |
| **Sit to stand from a chair without arms?** | | Yes  No | | | **Can they get up off the floor after a fall?** | | | | Yes  No | |
|  | | | | | | | | | | |
| **REFERRER’S DETAILS** | | | | | | | | | | |
| **Full name** | |  | | | | | | | | |
| **Role or relationship to client** | |  | | | | | | | | |
| **Telephone** | |  | | | | | | | | |
| **Email** | |  | | | | | | | | |

Please return this form to [**enquiries@activityismedicine.co.uk**](mailto:enquiries@activityismedicine.co.uk)