REFERRAL FORM A

For patients **WITHOUT** established heart disease.

LIVE active REFERRAL SCHEME

- To be completed by referring health professional.
- Please refer to the inclusion/exclusion criteria and patient pathway for further information on appropriate referrals and processes.
- Please fully complete the form to ensure appropriate exercise prescription.

PATIENT DETAILS

Please give **full postal address and telephone number** or attach label in order for patients to be contacted to attend a baseline appointment.

Name _____ Male/Female

D.O.B (day/month/year) _____

Address _____

_____ Postcode _____

Tel No Work _____ Home _____

Mobile _____

Hospital No. if known (GRI/VI/SHH/SGH/VI) _____

CHI No. _____

Does your patient require an interpreter/communication support?

If 'yes' please describe. _____ YES ☐ NO ☐

_____

REASON FOR REFERRAL PLEASE GIVE DETAILS BELOW

_____

_____

_____

1.If your patient has established heart disease please DO NOT use this form. Please use Referral Form for Patients with Established Heart Disease.

2. Is your patient motivated to become more active? YES ☐ NO ☐

If 'no' please DO NOT refer to the LiveActive Referral Scheme.

3a. Does your patient have high Blood Pressure YES ☐ NO ☐

3b. If YES is it being monitored/treated? YES ☐ NO ☐

4. Does your patient have any physical limitations that would make physical activity difficult? YES ☐ NO ☐

If 'yes' please give details using the options below

☐ Back Pain ☐ MS ☐ OA

☐ Amputation ☐ Osteoporosis ☐ RA

☐ Injury ☐ Chronic Fatigue ☐ Joint Replacement

☐ PVD ☐ Obesity ☐ Other Joint Pain

☐ Functional Post Stroke (please give details) ☐ Other (please give details)

_____

_____

_____

_____

GP DETAILS (or stamp)

Name _____

Practice Address _____

_____ Postcode _____

Tel No _____

Fax No _____

Practice Code _____

5. Does your patient have any mental health issues (e.g. anxiety, depression etc.)? Please give details YES ☐ NO ☐

_____

_____

_____

6. Does your patient have any learning difficulties or cognitive impairment? Please give details. YES ☐ NO ☐

_____

_____

Please note that patients must have the mental and physical ability to be able to participate in class based or individual based activity programmes. Patients with additional support needs must be accompanied by a carer (professional/voluntary). The LiveActive Referral Scheme is unable to provide one-to-one exercise tuition.

7. Does your patient have any respiratory problems?

Please give details. _____ YES ☐ NO ☐

_____

8. Is your patient diabetic? IDDM YES ☐ NO ☐

NIDDM YES ☐ NO ☐

9. Does your patient suffer from epilepsy? YES ☐ NO ☐

If 'yes' how often do they have a seizure

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

10. Is your patient taking any medication that will affect their exercise capacity? YES ☐ NO ☐

If 'yes' please attach repeat prescription printout

Based on this health profile, and my knowledge of the patient, I know of no reason why this patient should not join the Live Active Referral Scheme. This scheme involves a one to one behavioural consultation and advice on appropriate exercise and self monitoring (as per NHS GG&C protocol). Healthy eating and weight management behaviours will also be addressed if required. This information will be stored on a secure electronic database with additional paper copies stored securely as well.

Referrer's Signature _____

Print name _____ Date _____

Job title _____

Location & Tel (if different to GP details) _____

Please note all unsigned forms will be returned to the referrer

To the best of my knowledge I have given full and correct information on this form. I give permission for this information to be passed on to the LiveActive Referral Staff

Patient's Signature _____

Print name _____ Date _____

WHITE - SEND COPY TO PATIENT'S PREFERRED VENUE
YELLOW - REFERRERS COPY PINK - PATIENT'S COPY