EXERCISE (HEALTH) REFERRAL FORM

LEICESTER-SHIRE & RUTLAND SPORT
SPORT & PHYSICAL ACTIVITY

White copy to Exercise Referral Co-ordinator
Yellow copy Healthcare Professional to keep
Pink copy to be kept by patient

Please ensure health professional completes all required fields of the form.

Personal Information

Name of Practice/Hospital department: .....

Patients Name: ..... **D.O.B:** .....

Address: ..... **Postcode:** .....

Telephone No. ..... **Email:** ..... **Gender:** Male/Female (please circle)

Ethnic Origin (please circle) White Black African Black Caribbean Indian Pakistani Bangladeshi Chinese Other

Disability (please circle) Sensory Intellectual Physical Psychological Other (please state) .....

Please add any additional comment related to support needed .....

Referral Information: Please note that all patients referred onto this scheme must be more than 16 years of age.

Re-referral? ☐ Only one per patient

Please answer all of the following questions for either non cardiac or cardiac: Patients must be sedentary and meet one of the following criteria:

Reason for referral (non cardiac)

Inclusion Criteria (please tick)

- ☐ Smoking
- ☐ High cholesterol levels - mmol/L (consistently above 5.2 total cholesterol)
- ☐ Obesity/Overweight (BMI 25+)
- ☐ Hypertension (140/90 to 179/99 mmHg)
- ☐ Controlled diabetes
- ☐ Mild to moderate depression, stress or anxiety
- ☐ Mild to moderate Rheumatoid Arthritis/Osteoarthritis
- ☐ Controlled respiratory disease
- ☐ Back pain
- ☐ Diagnosed with Ostopenia/Osteoporosis
- ☐ Locomotive & neurological disorders

Other considerations .....

Medication .....

For more information regarding criteria please contact your local co-ordinator

Reason for referral (Heartsmart Cardiac Referrals)

Cardiac Status (please tick)

- ☐ MI: ..... Date: .....
- ☐ Angioplasty/Stent Date: .....
- ☐ CABG Date: .....
- ☐ Current Angina
  - ☐ At rest ☐ On exertion ☐ GTN
  - ☐ Arrhythmias ☐ Heart Failure
  - ☐ Pacemaker ☐ ICD

Relevant Past Medical History: .....

Investigations:

ETT ☐ Yes ☐ No Date: .....

Result: .....

LV Function ☐ Good ☐ Moderate ☐ Poor ☐ Unknown

Current Medication: (please tick)

- ☐ Aspirin ☐ Warfarin
- ☐ Clopidogrel ☐ Calcium channel blocker
- ☐ Anti-arrhythmic ☐ Ace Inhibitor
- ☐ Beta Blocker ☐ Statin
- ☐ Nitrate ☐ Diuretic Other .....
- ☐ High Cholesterol levels – mmol/L (consistently above 5.2 total cholesterol)

BP reading	**BMI/Weight (Kg/m²)**

Name of Health Professional: (please print) .....

Signature of Health Professional: .....

Practice Address/Hospital Department: .....

Date of Referral: .....

Patient Informed Consent - The exercise (Health) Referral Scheme has been fully explained to me. I am prepared to participate and give my consent for any relevant clinical information about my health to be transferred to the exercise professional and made available to Scheme Co-ordinators as required. In consent to my information being stored on a database

Signature of patient: .....

Practice/Hospital Department address .....

If you require further referral forms contact the physical activity team at Leicester-Shire and Rutland Sport on 01509 564873.

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