

Patient Referral Form

PATIENT DETAILS

NAME	<input type="text"/>	D.O.B.	<input type="text"/>
ADDRESS	<input type="text"/>	TELEPHONE	<input type="text"/>
	<input type="text"/>	POSTCODE	<input type="text"/>

REASON FOR REFERRAL (please tick all that apply)

BMI = >30 OR >25 + 1 OTHER MEDICAL CONDITION	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	OSTEOARTHRITIS/ OSTEOPOROSIS/ ESCAPE PAIN	<input type="checkbox"/>	CHRONIC FATIGUE SYNDROME/ME/ FIBROMYALGIA	<input type="checkbox"/>
ASTHMA + SMOKER OR INACTIVE	<input type="checkbox"/>	MENTAL HEALTH	<input type="checkbox"/>	JOINT INJURY OR LOWER BACK PAIN	<input type="checkbox"/>	HYPERTENSION/ POST PHASE III CARDIAC REHAB	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	COPD	<input type="checkbox"/>	PARKINSON'S DISEASE	<input type="checkbox"/>

Relevant medical history (past and current)

PREFERRED HORIZON LEISURE CENTRE

(please tick)

HAVANT
LEISURE CENTRE

WATERLOOVILLE
LEISURE CENTRE

MEDICATION

1. <input type="text"/>	2. <input type="text"/>	3. <input type="text"/>
4. <input type="text"/>	5. <input type="text"/>	6. <input type="text"/>

Any other implications?

Special Considerations/ Advice given:

DOCTOR'S OR HEALTH PROFESSIONAL'S DECLARATION

In my medical opinion, the above mentioned patient is able to undertake a suitable programme of physical activity. I will inform the gym manager if there is any significant change to the patient's health status.

SIGNATURE	<input type="text"/>	PRINT NAME	<input type="text"/>
PRACTICE NAME	<input type="text"/>	DATE	<input type="text"/>

PATIENT'S CONSENT

I agree to the release of medical details about me to relevant members of the Health Referral team. I understand that confidentially is assured. I am undertaking this programme on my own accord.

PATIENT SIGNATURE	<input type="text"/>	DATE	<input type="text"/>
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THIS REFERRAL IS ONLY VALID FOR 8 WEEKS FROM DATE OF ISSUE