

PHYSICAL ACTIVITY/EXERCISE REFERRAL TRANSFER FORM

Physical activity referral is one way of increasing physical activity levels of patients with specific medical conditions.

It may not be the most appropriate route for patients where there is no underlying medical condition or risk. A general recommendation to increase physical activity levels in order to gain health benefits may be all that is required if you consider the patient has reasonable motivation and resources to safely increase their physical activity levels.

Refer to the scheme inclusion criteria and use your professional judgement to determine whether the exercise referral scheme is the most appropriate route for the patient.

PLEASE COMPLETE THIS FORM IF THE PATIENT IS BEING REFERRED

To be completed by Referring Practitioner ONLY

Please complete all sections of the form, incomplete forms may be returned and your patient may be temporarily deferred until all relevant medical information is obtained.

PATIENT DETAILS		REFERRING PRACTITIONERS DETAILS	
Surname:		Name:	
Forename:		Position:	
Male/Female:		Address:	
Date of Birth:			
Address:		Postcode:	
Postcode:		Tel. No:	
		Fax. No:	
Contact Tel. No:		Email Address:	
NHS No:		Referral No:	
REGISTERED GP DETAILS (if different from referring practitioner)			
Name:		Address:	
Practice:			
Tel. No:		Postcode:	
Fax. No:			
Email Address:			
REASON FOR REFERRAL: Please check against scheme inclusion/exclusion criteria.			
<i>Insert list of conditions included in the scheme if preferred</i>			
MEDICAL INFORMATION: Please provide all relevant information about the patient's health status.			
Resting HR:		Systolic BP:	
		Diastolic BP:	
		BMI:	
MEDICAL CONDITIONS: Please give details of all relevant current and past health problems.			
Details <i>i.e. Previous history of Chronic Fatigue</i>		Dates <i>Diagnosed 20th May 2000</i>	

MEDICATION: Please provide a list of any medications being taken.	PHYSICAL LIMITATIONS: Please provide details any physical limitations
<i>i.e. Beta blockers</i>	<i>e.g. Arthritis of the hip</i>
ADDITIONAL RELEVANT INFORMATION: Please include any additional relevant information which has not been included in other parts of the form.	
<i>e.g. awaiting further investigations</i>	

AUTHORISATION	
I can confirm that the details given are a true reflection of the patient's medical history & medication, I refer this patient to the physical activity scheme under the terms & conditions set out in the protocol.	
Name of Referring Practitioner (PLEASE PRINT)	
Signature of Referring Practitioner	
Contact Telephone No.	
Date of Referral	

PATIENT CONSENT¹	
The Exercise Referral Scheme has been fully explained to me. I am prepared to participate and I give permission for this information to be passed to staff on the physical activity referral scheme.	
PLEASE PRINT YOUR NAME	
Signature of Patient	
Date	

IMPORTANT: This referral is valid for 3 months . If the patient fails to attend the initial consultation within 3 months of the date of referral and still wishes to participate in the referral scheme, the patient <u>must</u> see their Referring Practitioner in order to be re-referred. Physical Activity Referral Officers are advised <u>NOT TO ACCEPT</u> responsibility for a referred patient until all relevant clinical information is confirmed and signed. Referral letters or forms without this information or containing only blanket phrases such as 'I know of no reason why Mrs X should not engage in exercise' <i>are not acceptable as part of a quality referral system.</i>
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¹ All information in this form will be treated in the strictest confidence and stored securely according to the Data Protection Act 1998.

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PATIENT DETAILS		REFERRING PRACTITIONERS DETAILS	
Surname:		Name:	
Forename:		Position:	
Male/Female:		Address:	
Date of Birth:			
Address:			
		Postcode:	
Postcode:		Tel. No:	
Contact Tel. No:		Fax. No:	
NHS No:		Email Address:	
		Referral No:	
REGISTERED GP DETAILS (if different from referring practitioner)			
Name:		Address:	
Practice:			
Tel. No:			
Fax. No:			
Email Address:		Postcode:	
REASON FOR REFERRAL: Please check against scheme inclusion/exclusion criteria.			
<i>Insert list of conditions included in the scheme if preferred</i>			
MEDICAL INFORMATION: Please provide <u>all relevant</u> information about the patient's health status.			
Resting HR:	Systolic BP:	Diastolic BP:	BMI:
MEDICAL CONDITIONS: Please give details of <u>all relevant current and past</u> health problems.			
Details <i>i.e. Previous history of Chronic Fatigue</i>		Dates Diagnosed <i>20th May 2000</i>	

Patients Details:

Surname: The last name currently used by the patient.

Forenames(s): The forename(s) currently used by the patient, in the correct order.

Sex: Male or female gender of patient.

Date of Birth: Date of birth of patient.

Patient's Address and Postcode: The address and postcode to which correspondence should be addressed. This would normally be the patient's usual home address.

Telephone no: The patient's telephone contact number.

Medical Information:

This section of the form should include a current measurement of resting heart rate, blood pressure and body mass index. This section of the transfer form should include a comprehensive and relevant summary of the patient's current and past medical status.

Referring practitioners should include sufficient information to give a clear picture of the medical status of the patient. It may be appropriate to give information about the duration and severity of the medical condition the patient is being referred for. Sufficient information should be included so that the exercise professional can make an informed judgement about the most appropriate exercise intervention for the patient.

Referring Practitioners Details:

Name of Referring Practitioner: The name of the person making the referral

Position: The position of the person making the referral, e.g. practice nurse, dietician, physiotherapist

Referring Practitioners Address and Postcode: The address and postcode of person making the referral

Telephone/fax/e-mail: The telephone/fax/e-mail address of the referring practitioner.

Registered GP Details:

Name: The name of the general practitioner with whom the patient is registered.

Practice Address and Postcode: The address and postcode of the general practitioner with whom the patient is registered.

Telephone/fax/e-mail: The telephone / fax / e-mail address of the registered general practitioner.

Reason for Referral:

The referring practitioner should be explicit about why the patient is being referred to the scheme. This will help the receiving exercise professional understand the nature of, and reasons for, the referral. The 'reason for referral' may, *if desired*, include an indication of the expected referral outcome which, for example, aids the treatment and management of diabetes, treatment of borderline hypertension, weight management.

Medication:

This section of the form should include information about the medications the patient is currently taking and/or any recent drug treatment. The referring practitioner should also include information about any known impacts of the medication on the patient's everyday functional ability. The referring practitioner may also have knowledge of 'over the counter' preparations being used by the patient which should also be conveyed in this part of the form.

MEDICATION: Please provide a list of any medications being taken. <i>i.e. Beta blockers</i>	PHYSICAL LIMITATIONS: Please provide details any physical limitations <i>e.g. Arthritis of the hip</i>
ADDITIONAL RELEVANT INFORMATION: Please include any additional relevant information which has not been included in other parts of the form. <i>e.g. awaiting further investigations</i>	

Any Physical Limitations:

This section of the transfer form should include information about any factor(s) that might impact on the patient's functional ability or capacity to engage in physical activity.

It should also include any special considerations or advice given to the patient regarding the above.

Additional Relevant Information

(including patient's issues, social circumstances and special needs): This section of the form should contain additional relevant information which has not been included in other parts of the transfer form. Examples might include clinical or social information specific to the patient being referred; special needs relating to disability; ongoing clinical investigations, any exercise preferences for your patient.

Information could be conveyed here about any expectations or concerns the patient has expressed with respect to being referred to the scheme.

AUTHORISATION I can confirm that the details given are a true reflection of the patient's medical history & medication, I refer this patient to the physical activity scheme under the terms & conditions set out in the protocol.	
Name of Referring Practitioner (PLEASE PRINT)	
Signature of Referring Practitioner	
Contact Telephone No.	
Date of Referral	

Referring Practitioner's Signature and Date:

The referring practitioner should sign and date the referral form

PATIENT CONSENT The Exercise Referral Scheme has been fully explained to me. I am prepared to participate and I give permission for this information to be passed to staff on the physical activity referral scheme.	
PLEASE PRINT YOUR NAME	
Signature of Patient	
Date	

Patients Signature and Date:

The patient should sign and date the referral form.

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