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**South Cambridgeshire District Council**

**Exercise Referral Form**

**To the health professional:**

Physical activity referral is one way of increasing physical activity levels of patients with specific medical conditions. Please refer to the scheme inclusion criteria and use your professional judgement to determine whether the exercise referral scheme is the most appropriate route for your patient. Please complete this form if the patient is being referred.

**To the patient:**

The Active & Healthy 4 Life scheme provides a personal exercise programme drawn up and supervised by qualified instructors, making it easy for you to take up regular exercise. The programme consists of twice weekly sessions over a period of 12 weeks.

The initial appointment with your referral instructor will take place in private and involve a simple health assessment, completion of lifestyle and medical questionnaire and fulfilment of personal goal setting plans. These will help your instructor devise your personal exercise programme. Upon completion of the programme there is a final assessment where you can discuss your progress, the impact upon your health, and your plans for maintaining fitness.

**Charges**

The scheme is subsidised by South Cambridgeshire District Council, allowing a reduced charge to you of £3 per session. There is an additional charge of £8 for each of the two assessments. Charges are payable to the sports centre in two instalments of £44 each.

To make your initial appointment please call the sports centre of your choice from the list below. Take this form with you and give it to your Active & Healthy 4 Life scheme instructor.

Sports centres offering the Active & Healthy 4 Life scheme:

Cambourne Fitness & Sports Centre 01954 714070

Comberton Fitness Centre 01223 264721

Cottenham Sports Centre 01954 288760

Gamlingay Fitness Centre 01767 651785

Impington Sports Centre 01223 200404

Melbourn Sports Centre 01763 263313

Sawston Sports Centre 01223 712555

Swavesey Sports Centre 01954 234453

For further information and updates on the scheme visit www.scambs.gov.uk/active, call 01954 713070 or email AandH4L@scambs.gov.uk.

**SOUTH CAMBRIDGESHIRE: EXERCISE REFERRAL FORM**

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| **Date of referral:** | \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | |
| **Patient’s details** | | | | | | | | **Referrer’s details** | | | | | | | | |
| Name: | | | | | | | | Name: | | | | | | | | |
| Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | Profession: | | | | | | | | |
| Address: | | | | | | | | Surgery/Dept: | | | | | | | | |
| Post code: | | | | | | | | Telephone: | | | | | | | | |
| Contact number: | | | | | | | | Email: | | | | | | | | |
| Emergency contact name: | | | | | | | | Patient Registered medical practice: | | | | | | | | |
| Emergency contact number: | | | | | | | |  | | | | | | | | |
| **Baseline measurements within previous six months (complete if applicable)** | | | | | | | | | | | | | | | | |
| BP: | | RHR: | | | Cholesterol: | | | Weight (kg):  Height(cm): | | | | | BMI: | | Hba1c: | |
| **Reason for referral** Please tick all that apply | | | | | | | | | | | | | | | | |
| Asthma | | |  | | | Rheumatoid arthritis | | | |  | | | Stress | | |  |
| COPD | | |  | | | Simple mechanical back pain | | | |  | | | Anxiety | | |  |
| Osteoarthritis | | |  | | | Hypertension | | | |  | | | Diabetes: Type 1 | | |  |
| Osteoporosis | | |  | | | Hypercholesterolaemia | | | |  | | | Diabetes: Type 2 | | |  |
| Joint replacement | | |  | | | Depression | | | |  | | |  | | | |
| **Other (please specify):** | | | | | | | | | | | | | | | | |
| **Medication** Please provide a list of medication being taken, and what for OR provide by attaching prescription list | | | | | | | | | | | | | | | | |
| Medication (e.g. beta blockers): | | | | | | | | | Taken for (e.g. high blood pressure): | | | | | | | |
| Does the medication prescribed cause any of the following, which may affect the patient’s ability to exercise safely? | | | | | | | | | | | | | | | | |
| HR not indicative of exercise intensity | | | |  | | | Suppression of pain | | | |  | | | Dizziness | |  | |
| If there are any activities that you DO NOT wish your patient to take part in please indicate below: | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Health professional consent** | | | | | | | | | | | | | | | | |
| **To the best of my knowledge, the information provided is an accurate representation of the above patient’s health. I have discussed the exercise referral scheme with this patient and I believe them to be clinically stable and medically safe to participate in a tailored/prescriptive programme of physical activity.** | | | | | | | | | | | | | | | | |
| **Referrer’s signature:** | | | | | | **Print name:** | | | | | | **Date:**  \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | |
| **Patient consent** | | | | | | | | | | | | | | | | | |
| **The Active & Healthy 4 Life exercise referral scheme has been fully explained to me. I am prepared to participate and I give permission for my information to be passed to staff working on the scheme.**  **I understand that South Cambridgeshire District Council may use my anonymised data for monitoring and evaluation purposes, but not for any other purpose, and that my personal data will not be shared with any other organisation.**  **I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any worsening in my symptoms, any changes to my medication, and the results of any investigations or treatment.** | | | | | | | | | | | | | | | | | |
| **Patient’s signature:** | | | | | | **Print name:** | | | | | | **Date:**  \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | |