Exercise Referral Form (A)

Patient Name_____ **Hospital Unit No.** _____ (if known)

Home Address: _____

Post Code: _____ **Telephone No.** _____

Gender M / F (please circle) **D.O.B** ___/____/___ **Age** _____ **NHS No.** _____

ETHNICITY (please tick appropriate box)

A. White: ☐ English ☐ Scottish ☐ Welsh ☐ Irish ☐ Other . . . . . .
B. Mixed (dual heritage): ☐ White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐ Other . . . . . .
C. Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other . . . . . .
D. Black or Black British: ☐ Caribbean ☐ African ☐ Other . . . . . .
E. Any other ethnic group: ☐Chinese ☐ Travellers ☐ Yemeni ☐ Other . . . . . .
F. Do not wish to state: ☐

PRIMARY REFERRAL REASON (please tick as appropriate)

Does the patient have diagnosed CVD? Yes ☐ No ☐ (If yes, please specify)…….....

IF YES, PATIENT MUST BE REFERRED TO ACTION HEART

Is the patient being referred to reduce CVD risk? Yes ☐ No ☐

Please tick all other CHD risk factors that apply to this patient:

Family History	☐	Diabetes	☐	Hypertensive	☐	Anxiety/Stress	☐
Age +50yrs	☐	Smoker	☐	High Cholesterol	☐		
Male	☐	Depression	☐	Overweight	☐		

Any other referral reason? Yes ☐ No ☐ (If yes, please specify below)

_____

Factors which may affect the patient's ability to exercise (e.g. arthritis)

_____

REFERRAL DESTINATION - Please note that 'HIGHER RISK' patients (e.g. 3+ risk factors, highly significant or unstable risk factor, special needs) should be referred to ACTION HEART. Patients with less than 3 risk factors should be referred to a Leisure Centre / Healthy Hub setting.
(For further information please see pages 8-9 of the referral protocol)

Statement of Consent

I _____ (name of referrer, please print) Job title…….
refer the above patient under the terms and conditions of our mutually agreed protocol to:
_____ **Leisure Centre** ☐ **Action Heart** ☐ **Healthy Hub** ☐ (please tick)

Signature _____ Date of Referral___/___/___ Practice Courier No. ___

I the Patient understand the Exercise Referral Team will view and keep my personal details in order to deal effectively with my referral and for auditing and evaluation purposes in accordance with the Data Protection Act. Only anonymous details will be published without my expressed consent.

I agree that I may be contacted 6 months after the end of the scheme for evaluation purposes.

Print Name _____ Signature _____ Date ___/___/___

Please return this form to Action Heart or email action.heart@nhs.net or (Fax 01384 321090)