**Active 4 Health Lifestyle Hub - Exercise Referral Form**

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| **Dorset Council**  Active 4 Health  Lifestyle Coordinator | **Copy 1:**  Email to Lifestyle Coordinator  [*active4health@dorsetcouncil.gov.uk*](mailto:active4health@dorsetcouncil.gov.uk) | | **Copy 2:**  Printed Patient Copy | Participant ID |
| **Who can be referred?**  Patients with low, medium or high-risk conditions can be referred to Dorset Councils Active 4 Health Lifestyle Hub.  Patients will be supported into the most appropriate referral pathway to suit individual needs, interests and location. | | | | |
| **Health Professional: How do I refer?**   1. Autofill patient details 2. Add patient email address and phone number. 3. Add reason for referral and relevant medical information. 4. Ensure contraindications box is ticked. 5. Ensure the form is signed by you and patient. 6. Email to [*active4health@dorsetcouncil.gov.uk*](mailto:active4health@dorsetcouncil.gov.uk) 7. Give patient a copy of the form. | | **Patient: What do I do next?**   * Wait to receive an email from Active 4 Health Lifestyle Hub to let you know we have received your signed referral from your health professional. * Please email us if you have not heard within 10 working days [*active4health@dorsetcouncil.gov.uk*](mailto:active4health@dorsetcouncil.gov.uk)*.* * If you don’t have an email, a voice message can be left on 01202 795141, please give your full name and contact phone number. | | |
| **Exercise Referral Programmes and Activity Choice**  Dorset Councils Active 4 Health Lifestyle Hub will help connect patients to a suitable activity referral pathway.  The [Active 4 Health Lifestyle Hub](https://www.dorsetcouncil.gov.uk/w/active-4-health-lifestyle-hub) connects with a range of service providers who provide exercise referral across the Dorset Council area to provide choice and variety to suit patient locations, interests and health needs.  Activity choice depends on site and area, but includes a range of leisure centre, outdoor and community-based activities. 8-12 week exercise referral programmes including, gym sessions, indoor and outdoor fitness classes, swimming, Chair Fit, hydrotherapy, Falls Prevention classes, Back Care classes, Nordic Walking, Health Walks and Cycle Rides, Accessible Cycling. Specialist classes suited to high-risk patients including Cancer, Pulmonary, Stroke, Obesity and Diabetes, and Cardiac Phase 4 are also available.  Costs – vary between sites. | | | | |

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| **Date of Referral** (todays date) |  | | | |
| **PATIENT DETAILS** | | | **REFERRER DETAILS** | |
| **Full Name** | |  | **Full Name** |  |
| **Gender** | |  | **Profession**  i.e. GP, practice nurse, physio |  |
| **Date of Birth** | |  | **Practice** |  |
| **Address** | |  | **Address**  **Postcode** |  |
| **Postcode** | |  |
| **Home telephone number** | |  | **Telephone Number** |  |
| **Mobile number** | |  | **Registered GP name**  (if different from above) |  |
| **Email Address** | |  | | |

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| **Current Medication** | | | | | | | | | | | |
| **Medication:** | | | | | | | | | | |
| Acutes: |  | | | | | | | | | |
| Repeats: |  | | | | | | | | | |
| **MAIN REASON FOR REFERRAL:** Please do not refer anyone with absolute contraindications (see below) | | | | | | | | | | | |
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| **MEDICAL INFORMATION:** Please provide all recent and relevant information on the patients’ health status including dates | | | | | | | | | | | |
| **Blood Pressure** | |  | **Resting HR** |  | **BMI** |  |  | | **Cholesterol** |  | |
| **Sedentary lifestyle** | | | |  | | | | | | | |
| **At risk of falls** (include falls history) | | | |  | | | | | | | |
| **Hypertension/Hypotension** | | | |  | | | | | | | |
| **Diabetes** | | | |  | | | | | | | |
| **Coronary Artery Disease**  **\* Please fill out additional section below** | | | |  | | | | | | | |
| **Respiratory** | | | |  | | | | | | | |
| **Musculoskeletal** | | | |  | | | | | | | |
| **Stroke/TIA/Brain injury**  **\* Please fill out additional section below** | | | |  | | | | | | | |
| **Pre/Post Surgery** | | | |  | | | | | | | |
| **Cancer** | | | |  | | | | | | | |
| **Mental Ill Health** | | | |  | | | | | | | |
| **Autoimmune/neuromuscular** | | | |  | | | | | | | |
| **Neurological** | | | |  | | | | | | | |
| **Chronic Fatigue/ME** | | | |  | | | | | | | |
| **Epilepsy** | | | |  | | | | | | | |
| **Other** | | | |  | | | | | | | |
| **Any additional comments that may affect exercise:** | | | |  | | | | | | | |
| **Referrer’s Declaration:**  In my clinical opinion, the above-named patient is capable of undertaking a suitable exercise referral programme (please make sure the contraindications box at the bottom of the form is ticked). | | | | | | | | Signature:  Date: | | | |
| **Patient’s Declaration:**  I agree for the above information to be passed onto Dorset Councils Active 4 Health Service and give my consent to be contacted by the Lifestyle Coordinator. | | | | | | | | Signature:  Date: | | | |

**For Patients with Coronary Artery/Heart Disease ONLY**

**MUST HAVE COMPLETED PHASE 3 CARDIAC REHAB**

*Please tick box if applicable and provide dates where necessary*

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| **Phase 3 Cardiac Rehab complete?** | **No**  **Yes**  **Date of discharge:** | |
| **Heart Failure** |  | |
| **Myocardial Infarction** |  | |
| **Angioplasty / Stent** |  | |
| **Coronary Artery Bypass Surgery** |  | |
| **Implantable Cardioverter-Defibrillator (ICD)** |  | |
| **Current Dyspnoea** |  | |
| **Current Angina** | **At rest**  **On exertion** | |
| **Arrhythmias** | **Bradycardia**  **Tachycardia** | |
| **Other event(s)** |  | Date: |
| **Other event(s)** |  | Date: |
| **Information on any investigations undertaken** |  | |

**For Patients who have had a Stroke ONLY**

*Please tick box if applicable and provide dates/comments where necessary*

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| **NHS Rehabilitation service attended?** | | **No**  **Yes**   **Date of discharge:** | | |
| **Date of most recent stroke:** | |  | | |
| **General medical and stroke history:**  i.e. CVA dates, complications and co-morbidities that may restrict exercise/daily activities | |  | | |
| **Patient has or is susceptible to:** | **Hearing impairment**  **Impaired memory**  **Visual impairment**  **Impaired alertness** | | **Hemiparesis**  **Shoulder subluxation**  **Stroke related pain**  **MSK pain** | **Arrhythmia**  **Receptive Dysphasia**  **Expressive Dysphasia**  **Dysarthria** |

**ABSOLUTE CONTRAINDICATIONS – Do NOT refer**

**People with any current severe, UNSTABLE/UNCONTROLLED, condition.**

**The patient does NOT have any of the contraindications listed below  (tick to confirm)**

* **Resting systolic blood pressure >180mmHg**
* **Resting diastolic blood pressure >100mmHg**
* **Recent myocardial infarction (MUST have completed Phase 3 Cardiac rehab)**
* **New (< 1 month) or uncontrolled angina, or if it occurs at rest or at lower levels of exertion than normal**
* **New (< 3 months) or unstable diabetes and blood levels > 13mmol**
* **A recent change in resting ECG suggesting MI**
* **Symptomatic severe aortic stenosis**
* **Acute myocarditis or pericarditis**
* **Suspected or known dissecting aneurysm >4cm**
* **Unstable or acute cardiac event with fluid retention, excessive breathlessness, rapid weight gain, leg swelling or excessive tiredness**
* **New (< 3 months) or uncontrolled arrhythmias**
* **Uncontrolled resting tachycardia > 100bpm**
* **Experiences pain, dizziness or excessive breathlessness during exertion**
* **Symptomatic hypotension (during exercise) - Fall in SBP >20mg/Hg or DBP >10mg/Hg within 3 mins of standing**
* **Acute pulmonary embolus or infection**
* **Febrile illness or acute infection**
* **Other rapidly terminal illness**
* **Acute uncontrolled psychiatric/cognitive illness**
* **Recent injurious fall without medical assessment**