

Please ensure health professional completes all required fields of the form.

Personal Information

Name of Practice/Hospital department:

Patients Name: D.O.B:

Address: Postcode:

Telephone No. Email: Gender: Male/Female (please circle)

Ethnic Origin (please circle) White Black African Black Caribbean Indian Pakistani Bangladeshi Chinese Other

Disability (please circle) Sensory Intellectual Physical Psychological Other (please state)

Please add any additional comment related to support needed

Referral Information: Please note that all patients referred onto this scheme must be more than 16 years of age.

Re-referral? Only one per patient

Please answer all of the following questions for either non cardiac or cardiac: Patients must be sedentary and meet one of the following criteria:

Reason for referral (non cardiac)

Reason for referral (Heartsmart Cardiac Referrals)

<p>Inclusion Criteria (please tick)</p> <p><input type="checkbox"/> Smoking</p> <p><input type="checkbox"/> High cholesterol levels - mmol/L [consistently above 5.2 total cholesterol]</p> <p><input type="checkbox"/> Obesity/Overweight (BMI 25+)</p> <p><input type="checkbox"/> Hypertension (140/90 to 179/99 mmHg)</p> <p><input type="checkbox"/> Controlled diabetes</p> <p><input type="checkbox"/> Mild to moderate depression, stress or anxiety</p> <p><input type="checkbox"/> Mild to moderate Rheumatoid Arthritis/Osteoarthritis</p> <p><input type="checkbox"/> Controlled respiratory disease</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Diagnosed with Osteopenia/Osteoporosis</p> <p><input type="checkbox"/> Locomotive & neurological disorders</p> <p>Other considerations</p> <p>Medication</p> <p>For more information regarding criteria please contact your local co-ordinator</p>	<p>Cardiac Status (please tick)</p> <p><input type="checkbox"/> MI: Date:</p> <p><input type="checkbox"/> Angioplasty/Stent Date:</p> <p><input type="checkbox"/> CABG Date:</p> <p><input type="checkbox"/> Current Angina</p> <p><input type="checkbox"/> At rest <input type="checkbox"/> On exertion <input type="checkbox"/> GTN</p> <p><input type="checkbox"/> Arrhythmias <input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> Pacemaker <input type="checkbox"/> ICD</p> <p>Relevant Past Medical History:</p> <p>Investigations:</p> <p>ETT <input type="checkbox"/> Yes <input type="checkbox"/> No Date:</p> <p>Result:</p> <p>LV Function <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Poor <input type="checkbox"/> Unknown</p> <p>Current Medication: (please tick)</p> <p><input type="checkbox"/> Aspirin <input type="checkbox"/> Warfarin</p> <p><input type="checkbox"/> Clopidogrel <input type="checkbox"/> Calcium channel blocker</p> <p><input type="checkbox"/> Anti-arrhythmic <input type="checkbox"/> Ace Inhibitor</p> <p><input type="checkbox"/> Beta Blocker <input type="checkbox"/> Statin</p> <p><input type="checkbox"/> Nitrate <input type="checkbox"/> Diuretic Other</p> <p><input type="checkbox"/> High Cholesterol levels - mmol/L [consistently above 5.2 total cholesterol]</p>
BP reading	BMI/Weight (Kg/m²)

Name of Health Professional: (please print)

Signature of Health Professional:

Practice Address/Hospital Department:

Date of Referral:

Patient Informed Consent - The exercise [Health] Referral Scheme has been fully explained to me. I am prepared to participate and give my consent for any relevant clinical information about my health to be transferred to the exercise professional and made available to Scheme Co-ordinators as required. In consent to my information being stored on a database

Signature of patient:

Practice/Hospital Department address

If you require further referral forms contact the physical activity team at Leicester-Shire and Rutland Sport on 01509 564873.