

REFERRAL FORM

Client Contact Details			
Name			
Gender	Female <input type="checkbox"/> Male <input type="checkbox"/>	Date of Birth	
Address			
		Postcode	

Preferred method of contact			
<input type="checkbox"/> Telephone		<input type="checkbox"/> Mobile	<input type="checkbox"/> E-mail

Reason for referral i.e. Stroke/Cardiac/Cancer/MSK/Pain Management/Diabetes...

Active Options - Please provide details of any limiting factor for physical activity e.g. limited mobility, balance, breathing difficulties etc.

Cardiac Rehabilitation - Please indicate the relevant cardiac event for which you are referring the client			
<input type="checkbox"/> MI	Date	<input type="checkbox"/> Angioplasty/Stent	Date
<input type="checkbox"/> CABG	Date	<input type="checkbox"/> Pacemaker	Date
<input type="checkbox"/> ICD	Date		
<input type="checkbox"/> Other			

Cancer Self-Referral		
Diagnosis (type of cancer)	Stage (If Known)	<input type="checkbox"/> During or <input type="checkbox"/> After Treatment
Date of diagnosis	Type of Exercise wanted <input type="checkbox"/> Walks <input type="checkbox"/> Gym based <input type="checkbox"/> Group Circuit	

Relevant medical history (please select all that apply)	
<input type="checkbox"/> Cardiac conditions	<input type="checkbox"/> Surgery
<input type="checkbox"/> Muscle, bone, joint conditions	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Respiratory disease, e.g. COPD	<input type="checkbox"/> Hearing/visual impairment
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cancer
<input type="checkbox"/> Dementia	<input type="checkbox"/> Anxiety/Depression
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other/Comments	

Authorisation - I refer the above client to the physical activity scheme under the terms set out in the referral form			
Signature of Referrer		Print Name	
Designation		Place of Work	
Telephone		Date of Referral	
Email			

Self-referral (<i>For Persons with a Cancer diagnosis only</i>)			
Signature		Date	

Client Declaration

The information you provide in this form will be kept confidential and held by Fife Sports and Leisure Trust on a secure database. Information will be used by authorised Fife Sports and Leisure Trust staff to help you plan your activity programme, and will also be used by Fife Sports and Leisure Trust for statistical purposes with all statistical data remaining anonymous Fife Sports and Leisure Trust will share your data with funders (on an anonymous basis) and may require to share your data with third parties if you suffer an injury or another medical emergency.

I hereby consent to my data being used in accordance with the statement above and declare that to the best of my knowledge there is no reason why I should not participate in a physical activity programme. I understand that I take part in any recommended programme entirely at my own risk and waive any legal recourse for damages arising from my participation. I also understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. I will also inform the instructor of any changes in my medication as soon as possible.

Client GDPR Agreement confirmed via phone call Yes No

Date

H&PA Team Signature

Referral Submission

Please send completed form via email to healthwellbeing@fifeleisure.org.uk or by post to the address detailed below:

Health & Physical Activity Team, Fife Sports and Leisure Trust, Duloch Leisure Centre, Nightingale Place, Dunfermline KY11 8LW