|  |
| --- |
| Practice Details |

|  |  |  |
| --- | --- | --- |
| Referrer Name:  Click here to enter text. |  | Practice Name:  Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| Referrer Position:  Click here to enter text. |  | Practice Number:  Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| Email:  Click here to enter text. |  | Practice Fax:  Click here to enter text. |

|  |
| --- |
| I recommend the named patient to participate in the Active Lifestyle on Referral Scheme and confirm that I have assessed this patient, to my knowledge meets the referral criteria and that there is no medical reason why they should not participate. I confirm that I will keep the Healthy Lifestyle Manager updated with any relevant health changes and that I have discussed the service with the patient.  **Please Tick:** |

|  |
| --- |
| Patients Details |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patients Name:  Click here to enter text. |  | Title: |  | Date of Birth:  Click here to enter text. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Address:  Click here to enter text. | | |  | | Mobile No:  Click here to enter text. |
|  | |  |
|  | | Phone No:  Click here to enter text. |
|  | |  |
| Post Code: Click here to enter text. | | |  | | Email:  Click here to enter text. |
|  | | |  | |  |
| I consent to participation in the Active Lifestyle on Referral Scheme, the nature and purpose of which has been explained by my GP/referring health promotional. I consent to the release of relevant medical information about myself to the Healthy Lifestyle Manager and partners. Information obtained will be treated as confidential, although it may be used in anonymous form for statistical or research purposes. I give permission for my GP/referring health professional to be kept informed on my progress and for the Healthy Lifestyle Manager to contact me concerning my adherence to the Programme.  **Please Tick:**  **Date:** Click here to enter text. | | | | | |
|  | | | | | |
| **Essential Criteria** |  | **Clinical Inclusion Referral Criteria** | | | |
| * Adults Age 18+. * Registered with a GP in South Gloucestershire. * Meet as least one of the Clinical * Inclusion Referral criteria. * Sufficiently motivated to want to   increase their physical activity levels.   * **Be Inactive** (not currently meeting the Chief Medical Officer's recommendation for physical activity   of 150 minutes per week. |  |  | | 20% CHD risk | |
|  |  | | Hypertension – (controlled) | |
|  |  | | Diabetes – (controlled) | |
|  |  | | Unhealthy Weight (BMI > 30 kg/ m2 or> 27 for BME | |
|  |  | | COPD, Asthma - mild to moderate | |
|  |  | | High Total Cholesterol Levels (consistently> 5.2mmol/L) | |
|  |  | |
|  |  | | Suffer from mild to moderate Rheumatoid Arthritis or Osteoarthritis | |
|  |  | | Patients requiring Musculoskeletal Rehabilitation | |
|  |  | | Mild to moderate Mental Health Condition Depression / Anxiety / Stress | |

|  |
| --- |
| **Criteria NOT appropriate for this scheme:** |
| * Phase Ill Cardiac Rehab - has historically been delivered in a hospital setting in the form of structure exercise programming with educational and psychological support. * Phase lll Osteoporosis * Claudication/ Unstable Angina * Resting or Uncontrolled Tachycardia > 100bpm * Unstable or Acute Heart Failure * Unstable Diabetes * Mental Health (psychotic illness) * Dementia Care * Palliative Care * Acute Pulmonary Embolus or Pulmonary infarction - DVT |

|  |
| --- |
| *Current I Past Health Problems not mentioned above (all condition must be stable):* |
| Click here to enter text. |

Current Medication:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. | Click here to enter text. |  | 4. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2. | Click here to enter text. |  | 5. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 3. | Click here to enter text. |  | 6. | Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| Weight  Click here to enter text. KG |  | Height  Click here to enter text. CM |

|  |  |  |
| --- | --- | --- |
| BMI  Click here to enter text. |  | Resting Heart Rate  Click here to enter text. BPM |

|  |  |  |
| --- | --- | --- |
| Blood Pressure  Click here to enter text. |  |  |

|  |  |  |
| --- | --- | --- |
| Jim Rollo  Healthy Lifestyle Manager  jim.rollo@circadiantrust.org  Tel: 01454 279964 |  |  |