Exercise Referral From

Patient/Client Details

Surname_____ Forename_____

D.O.B_____ M/F

Telephone_____

Address_____

_____

Patient's GP_____

Practice Address_____

_____Telephone_____

Next of Kin (for emergency contact)

Name_____

Relationship_____ Telephone_____

Known Medical Conditions *(please circle)*

Obesity	Osteoarthritis	Rheumatoid Arthritis
Osteoporosis	Joint Replacement	Simple Mechanical Lower
Asthma	COPD	Back Pain
Anxiety	Depression	Stress
Diabetes Type 2	Hypercholesterolemia	Diabetes Type 1
CHD/ Angina	Other	Hypertension

Further Information_____

_____

Medication

1	**2**
3	**4**
5	**6**
7	**8**

Other clinical diagnoses or health problems (please give details)

_____

_____

_____

Seated BP_____ Resting HR_____

Details of any exercise exclusions/limitations_____

_____

_____

Referrers Name and Medical Profession_____

_____

Referrers Signature_____

Date_____

Patient Consent

Signature_____

Date_____

Please note these details will be kept private and confidential.

Please send completed forms to:
Claire Gurney (Cardiac Rehabilitation and Exercise Referral Instructor)
21 St Michael at Pleas
Norwich
NR3 1EP

Tel: 07776044304 / 01603 946893

Alternatively forms can be kept by the patient and taken by them to the gym, after they have contacted Claire (instructor)