

Fitter Futures Referral Form

Patient details		Date of referral:	
Name:		Disability:	
Gender:		Date of Birth:	
Address:		Ethnicity:	
Postcode:			
Telephone Number:		Email:	
Referrer's details:			
Name:		Profession:	
*GP Practice: (please give M code)	Organisation/Hospital:	Department:	
Telephone Number:		Email:	
*Patient's registered GP Surgery must be included within all referrals			
Service Information			
Preferred service provider <u>Please select ONE service</u>		Physical Activity on Referral - Preferred leisure centre (if known):	
		Slimming World - Adult Weight Management: Group programme: weekly support session where no foods are banned, so meals offer balance and variety, and are family friendly. Achieved using a Food Optimising Plan.	
		WW (new Weight Watchers) – Adult Weight Management: Group programme: weekly support centred on a holistic programme for weight loss and wellness, guiding you to a healthy eating pattern.	
		Everyone Health – Adult Weight Management: Group programme: 90-minute weekly support including fun and interactive practical nutrition activities alongside group physical activity sessions.	
Reason for Referral (for cardiac rehab please see additional questions on the reverse)			
Clinical diagnosis / current medical conditions relevant to referral			
BMI			
Current Medication			

ESSENTIAL: Please sign on behalf on the patient if verbal consent is provided – referrals will not progress without consent

I would like to access services available through Fitter Futures Warwickshire. I understand that some of the services are free, but others are chargeable at a reduced price. The options and costs will be discussed at the first meeting. I agree that my details can be used as part of monitoring and evaluation process of Fitter Futures Warwickshire. If the patient is under 18, please get a parent/guardian to complete this section

Name:

Relationship to patient - If patient is under 18 years:

Telephone number:

E mail address:

Please sign to agree:

Date:

Return form to: Fitter Futures Team, Customer Service Centre, Shire Hall, Market Place, Warwick, CV34 4RL

Referrals can be made online via: warwickshire.gov.uk/businessportal

Email: fitterfutures@warwickshire.gov.uk and Telephone: 01926 351 077

For more information about Fitter Futures Warwickshire Privacy Notice: www.warwickshire.gov.uk/privacy

Cardiac Rehabilitation Referrals Only

Please indicate with a yes/no for each, whether the applicant has been diagnosed with any of the conditions listed. If yes, please provide the most recent incidence.

Myocardial Infarction:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Angioplasty/Stent:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arrhythmias:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Atrial Fibrillation:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Current Dyspnoea:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Coronary Artery By Pass Graft:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Current Angina:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stable Heart Failure:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lung function:	Good <input type="checkbox"/> Moderate <input type="checkbox"/> Poor <input type="checkbox"/>
Implantable Cardioverter Defibrillator:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date:	

Medication – Please tick those currently taken

Aspirin <input type="checkbox"/>	GTN Spray/Tablets <input type="checkbox"/>	Warfarin <input type="checkbox"/>
Lipid Lowering <input type="checkbox"/>	Calcium Channel Blocker <input type="checkbox"/>	Other Oral Anti-Coagulant <input type="checkbox"/>
Beta – Blocker <input type="checkbox"/>	Potassium Channel Activators <input type="checkbox"/>	Anti – Arrhythmic <input type="checkbox"/>
Alpha Blocker <input type="checkbox"/>	Ivabradine <input type="checkbox"/>	Insulin <input type="checkbox"/>
ACE Inhibitor Blocker <input type="checkbox"/>	Angiotensin II Receptor <input type="checkbox"/>	
Nitrate <input type="checkbox"/>	Diuretic <input type="checkbox"/>	

Other Medication/Comments:

Is this patient clinically stable without any of the below contraindications to exercise:

- Unstable angina
- Unstable or acute heart failure
- Unstable diabetes
- New or uncontrolled atrial or ventricular arrhythmias
- Resting or uncontrolled tachycardia (> 100bpm)
- Resting systolic blood pressure > 180mmHg & / or resting diastolic blood pressure > 100mmHg
- Symptomatic hypotension or BP drop > 20 mmHg demonstrated during ETT
- Febrile illness.

Tick to confirm the above and that the patient is compliant with medication: Yes No