Fitter Futures Referral Form

Patient details	**Date of referral:**
Name:	Date of Birth:
Gender:	Ethnicity:
Address: Postcode:	Telephone Number:
Email:	

Referrer's details:		
Name:	Profession:	
*GP Practice:	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.
		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)	□ Cardiac □ Diabetes Type 1 and 2 □ Early to Mid-stage Dementia □ Hypertension □ Mental Health (Mild to Moderate) □ Muscular skeletal conditions □ Neurological condition □ Obesity/Overweight □ Obesity/Overweight with additional concerns □ Overweight and Postnatal □ Overweight and Pregnant □ Osteo/Rheumatoid/Arthritis/Osteoporosis □ Recovering from Cancer □ Respiratory Condition □ Risk of Cardiovascular Disease □ Strength and Balance Concerns	
Body Mass Index		
Current Medication		

Patient consent on reverse of the referral form

ESSENTIAL: Referrer Authorisation
1. Does the patient consent to the data on this being shared with local delivery partners? Tick box for yes only □ 2. I (Health Professional) can confirm the details given are a true reflection of the patient's medical history. The patient is compliant with their medication and is safe to exercise. Tick box for yes only □

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 and www.warwickshire.gov.uk/directory-record/1266/fitter-futures

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 □ No □	Pacemaker:	Yes □ No □
Angioplasty/Stent:	Yes □ No □	Arrhythmias:	Yes □ No □
Atrial Fibrillation:	Yes □ No □	Current Dyspnoea:	Yes □ No □
Coronary Artery Bypass Graft:	Yes □ No □	Current Angina:	Yes □ No □
Stable Heart Failure:	Yes □ No □	Lung function:	Good □ Moderate □ Poor □
Implantable Cardioverter Defibrillator:	Yes □ No □	Date:	

Medication – Please tick those currently taken					
Aspirin	□	GTN Spray/Tablets	□	Warfarin	□
Lipid Lowering	□	Calcium Channel Blocker	□	Other Oral Anti-Coagulant	□
Beta – Blocker	□	Potassium Channel Activators	□	Anti – Arrhythmic	□
Alpha Blocker	□	Ivabradine	□	Insulin	□
ACE Inhibitor Blocker	□	Angiotensin II Receptor	□		
Nitrate	□	Diuretic	□		
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 □