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 –** There are costs associated with this service. 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. This service is free.
		Everyone Health – Adult Weight Management: Group programme: 90-minute weekly support including fun and interactive practical nutrition activities alongside group physical activity sessions. This service is free.
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 □