

# Section 6 Appendix

## Healthwise Referral Form

(Please complete in BLOCK capitals. All items in this section must be fully completed)

Patient Details	Referrer Details
Name: .....	Name: .....
Address: .....	Profession: .....
Post Code: .....	Surgn/Dept: .....
Tel Home: .....	Address: .....
Tel Work: .....	Post Code: .....
D.O.B: ...../...../.....	Tel No: .....
Age: .....	Email address: .....
Ethnicity: .....	Occupation: .....
Emergency contact: .....	

### Medical Details

(Please complete in BLOCK capitals. All items in this section must be fully completed)

#### 1. Current Cardiac Status

BP	Resting HR	BMI	Blood Glucose
----	------------	-----	---------------

#### 2. Reason for Referral (please refer to inclusion criteria)

CHD risk	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Diabetes Type I	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	CFS	<input type="checkbox"/>	Diabetes Type II	<input type="checkbox"/>
Intermittent Claudication	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Depression	<input type="checkbox"/>
COPD	<input type="checkbox"/>	Stress/Anxiety	<input type="checkbox"/>	Obesity	<input type="checkbox"/>
Osteoporosis / Arthritis	<input type="checkbox"/>	Pre/Post surgery	<input type="checkbox"/>	Asthma	<input type="checkbox"/>

Other, please list .....

#### 3. Additional Medical Conditions Past and Present

.....

.....

.....

#### 4. Medication/Dosage (attach extra sheet if necessary)

.....

.....

.....

#### 5. Relevant Family Medical History

.....

.....

#### 6. The Physical Activity Referral Scheme:

I have discussed the Healthwise scheme with this patient and believe they are ready to participate in a physical activity programme. She meets the inclusion criteria  (p/s tick)

#### 7. Preferred Site:

Britannia  Kings Hall

#### Patient Consent

I agree for the information on this form to be passed onto the Healthwise PARS team. I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. I am ready to undertake a programme of physical activity and understand the benefits and potential implications that exercise may have.

I will inform the instructor of any change in my medication and the results of any investigations or treatments. I understand that this may effect my inclusion to the Healthwise scheme.

Patient signature: .....

Date: .....

#### Referrer Consent

The information on this form is an accurate representation of this Patient's health status. If I am aware that this status changes, I will endeavour to inform Healthwise.

Referrer signature: .....

Print Name: .....

Date: .....

**Please note:** This form should be completed and signed by both Referrer and Patient and posted to: Healthwise Britannia Leisure Centre, 40 Hyde Road, London, N1 5JU  
Tel: 020 7749 7645

## Cardiac Referral Form (Form 1)

(To be completed by Phase III Cardiac Professional ONLY)

Patient Details		Referrers Details	
Name:	.....	Name:	.....
Address:	.....	Profession:	.....
Post Code:	.....	Surgery/Dept:	.....
Tel Home:	.....	Address:	.....
Tel Work:	.....		.....
D.O.B:	...../...../.....	Post Code:	.....
Age:	.....	Tel No:	.....
Ethnicity:	.....	Email address:	.....
Occupation:	.....		.....
Emergency contact:	.....		.....

## Medical Details

(Please complete in BLOCK capitals. All items in this section must be fully completed)

### 1. Current Cardiac Status

BP  HR  REG/IRREG

Diagnosis: ..... Date: ..... Angioplasty/Stent: Y/N Date: .....  
 LV Function: Good/Moderate/Poor Date: .....  
 Complications: Y/N Assoc Heart Failure: Y/N Mild/Moderate  
 Current Angina: (post MI or CABG) Y/N GTN: Y/N  
 Angiogram: Y/N - Date ..... Comments: .....  
 ETT Protocol: Full/modified Bruce Date: ..... Completed: Y/N (pped:  
 Mins: ..... Incidence: ..... (reason) .....

### 2. Phase III

Has the client attended phase III: Y/N. If Yes, Where: .....  
 Date commenced: ..... Date Completed: .....  
 How many minutes CV achieved: .....  
 METS: .....

### 3. CHD Progressive Risk Factors, (refer to inclusion criteria)

Family History  Excess Alcohol  Diabetes Type I   
 Hyperlipidemia  CFS  Diabetes Type II   
 Sedentary  Smoking  Obesity   
 Hypertension  Stress  Other

### 4. Additional Medical Conditions Past and Present

.....  
 .....

### 5. Medication/Dosage (attach extra sheet if necessary)

.....  
 .....

**6. The Physical Activity Referral Scheme:** I have discussed the Healthwise scheme with this patient and believe they are ready to participate in a physical activity programme. S/he meets the inclusion criteria  (pls tick)

### Patient Consent

I agree for the information on this form to be passed onto the Healthwise PARS team. I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. I am ready to undertake a programme of physical activity and understand the benefits and potential implications that exercise may have. I will inform the instructor of any change in my medication and the results of any investigations or treatments. I understand that this may affect my inclusion to the Healthwise scheme.

Patient signature: ..... Date: .....  
 Print Name: .....

### Referrer Consent

The information on this form is an accurate representation of this Patients health status. If I am aware that this status changes, I will endeavour to inform Healthwise.

Referrer signature: ..... Date: .....  
 Print Name: .....

**Please note:** This form should be completed and signed by both Referrer and Patient and posted to: Healthwise Britannia Leisure Centre, 40 Hyde Road, London, N1 5JU  
 Tel: 020 7749 7645

# Section 6 Appendix

## Cardiac Referral Form (Form 2) - CHD GP Referral Form

(To be completed by the referring Doctor or designated health professional)

Patient Details	Referrer Details
Name: .....	Name: .....
Address: .....	Profession: .....
Post Code: .....	Surgery/Dept: .....
Tel Home: .....	Address: .....
Tel Work: .....	.....
D.O.B: ...../...../.....	Post Code: .....
Age: .....	Tel No: .....
Ethnicity: .....	Email address: .....
Occupation: .....	.....
Emergency contact: .....	.....

### Cardiac History

MI: Yes  No  Date: .....

Angioplasty / Stent: Yes  No  Date: .....

CABG: Yes  No  Date: .....

Other: Yes  No  Date: .....

Current Angina: Yes  No  On exertion: Yes  No

GTN: Yes  No  Details: .....

Atrialfibril: Yes  No  Comments: .....

At rest: Yes  No  .....

### Current Medication (attach prescription list if available) ✓ if prescribed

Aspirin  Warfarin  Diuretic  Nitrate

Clopidogrel  Calcium channel blocker  GTN  Other: .....

Anti-arrhythmic  Statin  .....

### Investigations (if available)

ETT: Yes  No  Date: ..... Result: ..... Moderate  Poor

LV Function: Good  Moderate  Poor

### Current Status - CHD Risk Factors

Resting BP: ..... Resting Heart Rate: ..... Stable Type 1/Type 2 Diabetes

BMI: ..... Cholesterol: ..... Physically Inactive  Smoker

Excess Alcohol  Stress

### Past Medical History (✓ if applicable, please supply dates & details as far as possible)

COAD / Asthma  Epilepsy  Hypertension  Claudication

CVA / Neuro. Problems  Ortho/muscle, skeletal problems

Details: .....

Other considerations: .....

### Important Notice

- The patient exhibits no contraindication to exercise (as indicated on the protocol)
- The patient is clinically stable
- The patient is compliant with medication
- The patient is awaiting / not awaiting medical or surgical treatment (see protocol)

Referrer signature: ..... Date: .....

Print Name: .....

GP's signature (if different from above): ..... Date: .....

Print Name: ..... Date: .....

### Patient Consent

I agree for the information on this form to be passed onto the Exercise Instructor. I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. I will also inform the instructor of any change in my medication and the results of any investigations or treatments.

Patient signature: ..... Date: .....

Print Name: ..... Date: .....

**Please note:** This form should be completed and signed by both Referrer and Patient and posted to: Healthwise Brianna Leisure Centre, 40 Hyde Road, London, N1 5JU  
Tel: 020 7749 7645