**Referral for Active Health**

***Please complete all sections of the form, incomplete forms may be returned and your patient may be temporarily deferred until all relevant medical information is obtained***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient/Client Details** | | | | | |
| Surname: | | | Forename: | | |
| DOB: | Gender: M/F/Transgender/Non Binary/Other/Prefer not to say | | Previous/Maiden Name: | | |
| Address: | | | GP Name & Address: Dr | | |
| Tel No: | | | GP Tel No: | | |
| Ethnicity: | | | Patient Health Checks | | |
| Next of Kin/emergency contact: | | | Height: | | Weight: |
| BMI: | | Resting HR: |
| Comments: | | | Seated BP: | | |
|  | | |
| **Primary Reason(s) for Referral:**   * Strong & Steady (Neurological Conditions) * Fit 4 Function (Falls Prevention, balance, coordination) * Exercise after stroke * Cardiac Rehab * Pulmonary Rehab * Gym exercise referral * Swim referral * Exercise for lower limb Osteoarthritis * Falls Prevention * Connecting to Wellbeing (social isolation, general wellbeing) * Fit 4 Life (adult weight management) * Fit 4 Future (Cancer rehab) * Healthy Families (child weight management 4 – 19 years) * Seated Exercise | | | | | |
| **Known medical conditions**   * Obesity * Osteoporosis * COPD * Anxiety * Type 2 Diabetes * Hypercholesterolemia * Pulmonary disease | | * Osteoarthritis * Asthma * Multiple Sclerosis * Depression * Hypertension * Joint Replacement | | * Rheumatoid Arthritis * Cystic Fibrosis * CFS * Type 1 Diabetes * Angina * Cancer; type …………………………... | |
| Medication: (where possible please attached a printed list of medications) | | | | | |
| Other information (including other clinical diagnoses and/or current health problems/recent medical procedures/pending investigations/mobility barriers): | | | | | |
| **PATIENT CONSENT:** The Active Health Scheme has been fully explained to the patient. The patient gives permission for this information to be passed to Active Health team**.** | | | | | |
| **AUTHORISATION.** I can confirm that I have spoken to the individual about the Active Health Scheme and the individual is happy for the referral to be made.  **Name of Referring Medical Professional (PLEASE PRINT)**  **……………………………………………………………………… Dept...……………………………..**  **Signature of Referring Medical Professional**  **……………………………………………..…………………………………………………………………**  **Date of Referral…………………………………………………………………………………………..** | | | | | |

**For quickest response, please email completed form to Active.Health@brimhamsactive.co.uk (secure)**

If you require more detail please call 01423 556106

**How we use your Information**

Any information you give to us will be held securely and in accordance with the rules on data protection. We will treat personal details as private and confidential and safeguard them. We will not disclose them to anyone unconnected with the Council unless you have consented to their release or in certain circumstances where:

* + We are legally obliged to do so;
  + Disclosure is necessary for the proper discharge of our statutory functions;
  + Disclosure is necessary to enable us to provide you with a requested service or deal with your enquiry;
  + ‘Legitimate interests’ are relied on in relation to specific processing operations.
  + We are under a duty to protect public funds.

We may use the information you have provided for the prevention and detection of fraud. We may also share this information with other bodies responsible for public funds or for auditing them for these purposes.

For more information on privacy and how we use your data please take a look at our privacy notice at

<https://www.brimhamsactive.co.uk/privacy>