Dudley Metropolitan Borough Council

Action Heart

NHS Dudley Public Health

Exercise Referral Form (A)

Patient's Name .....Hospital Unit No. .....(if known)
Home Address .....
Postcode: .....Telephone No: .....
Gender M / F (please circle) D.O.B ...../...../..... /.Age .....NHS No. .....

ETHNICITY (please tick appropriate box)

A. White ☐ English ☐ Scottish ☐ Welsh ☐ Irish ☐ Other .....
B. Mixed (dual heritage) ☐ White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐ Other .....
C. Asian or Asian British ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other .....
D. Black or Black British ☐ Caribbean ☐ African ☐ Other .....
E. Any other ethnic group ☐ Chinese ☐ Travellers ☐ Yemeni ☐ Other .....
F. Do not wish to state ☐

PRIMARY REFERRAL REASON (please tick as appropriate)

Does the patient have diagnosed CVD ? Yes ☐ No ☐

IF YES, PATIENT MUST BE REFERRED TO ACTION HEART

Is the patient being referred to reduce CVD risk ? Yes ☐ No ☐

Please tick all other CHD risk factors that apply to this patient

Family History ☐ Diabetes ☐ Hypertensive ☐ Overweight ☐ Smoker ☐ High Cholesterol ☐
Anxiety/Stress ☐ Depression ☐ Age +50yrs ☐ Male ☐

Any other referral reason ? Yes ☐ No ☐ (please specify)

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Factors which may affect the patient's ability to exercise (eg. arthritis)

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REFERRAL DESTINATION

Please note that 'HIGHER RISK' patients (e.g. 3+ risk factors, highly significant or unstable risk factor, special needs) should be referred to ACTION HEART. Patients with less than 3 risk factors should be referred to a Leisure Centre / Healthy Hub setting.
(For further information please see pages 8-9 of the referral protocol)

Statement of Consent

I ..... (print name)
refer the above patient under the terms and conditions of our mutually agreed protocol to:
.....**Leisure Centre** ☐ **Action Heart** ☐ **Healthy Hub** ☐ (please tick)

Signature .....Date of Referral .....Practice Courier No. .....

I the Patient understand the Exercise Referral Team will view and keep my personal details in order to deal affectively with my referral and for auditing and evaluation purposes in accordance with the Data Protection Act. Only anonymous details will be published without my expressed consent

Print Name .....Signature .....Date .....

*PLEASE ATTACH A MEDICATION LIST TO THIS FORM (optional)