

**Thank you for choosing Urban Health & Fitness exercise referral service.**

This service provides prescriptive gym programmes, selected classes and services for people with a long term health condition(s). Please note that this service is available to any person aged 18 years plus, living in and around BCP/Dorset/Hampshire area and who is currently inactive and lives with a long-term medical condition. This service is subsidised but payable and available for a minimum of 12-weeks following enrolment.

**Health professionals – what to do next:**

1. Complete the referral form,
2. E-mail or hand the completed form to the **PATIENT**.

Please note – the service should not be used to replace clinical rehabilitation or physiotherapy, where this is required by the patient.

**Patient/client – what to do next:**

1. Email [hello@urbanhealthfitness.com](mailto:hello@urbanhealthfitness.com) or call **01202 914848** and book into your 1st appointment with our exercise referral specialist.
2. Or come in and speak to a member of the team to get started.

Exercise referral form – to be completed in FULL by a health professional.	
<b>Patient Details</b>	
<b>Name</b>	
<b>Date of Birth</b>	
<b>Address + Post Code</b>	
<b>Contact Telephone</b>	
<b>Email</b>	
<b>Registered Medical Practice</b>	

Exercise Referral Form Referring Professional Details	
<b>Name</b>	
<b>Profession</b>	
<b>Surgery/Department</b>	
<b>Contact Telephone</b>	
<b>Email</b>	

**Baseline Measurements (within previous 6 months, if known)**

BP	RHR	BMI

<b>Primary Reason for Referral e.g. lose weight, glucose control, cancer rehab.            Please note 'general fitness' not acceptable without a presenting medical condition.</b>	
<input type="checkbox"/> Other Medical Conditions <input type="checkbox"/> Asthma COPD Anxiety Disorder <input type="checkbox"/> Chronic Back Pain Cancer – give type: <input type="checkbox"/> Established CHD, Angina or Previous MI (See Point 6) <input type="checkbox"/> Hypertension Neurological Conditions – give type:	<input type="checkbox"/> Osteoarthritis Rheumatoid Arthritis BMI>30 <input type="checkbox"/> Stroke/TIA – give date: <input type="checkbox"/> Diabetes: Type 1 Type 2 Family History <input type="checkbox"/> Other – specify: <input type="checkbox"/> Current Medication and Dosage (attach prescription list if easier) <input type="checkbox"/> Cardiac History

Health Professional Declaration	
To the best of my knowledge, the information provided on this form is an accurate representation of the patient's health and medical background. I have discussed the exercise referral programme with this patient and I believe that the patient is clinically stable and medically safe to participate in a tailored/ prescriptive programme of physical activity.	
<b>Signature</b>	<b>Date</b>
Patient Consent	
I agree that the above information is correct and consent for my medical information to be kept within data protection guidelines by the exercise referral service, once I have registered for the service.	
<b>Signature</b>	<b>Date</b>