Horizon Leisure Centres Health Referral Scheme

Patient Referral Form

PATIENT DETAILS

NAME		D.O.B.	
ADDRESS		POSTCODE	
EMAIL		TELEPHONE	
EMERGENCY CONTACT		EMERGENCY NUMBER	

REASON FOR REFERRAL (please tick all that apply)

BMI = >30 OR >25 + 1 OTHER MEDICAL CONDITION	☐	DIABETES	☐	OSTEOARTHRITIS/ OSTEOPOROSIS/ ESCAPE PAIN	☐	CHRONIC FATIGUE SYNDROME/ME/ FIBROMYALGIA	☐
ASTHMA + SMOKER OR INACTIVE	☐	MENTAL HEALTH	☐	JOINT INJURY OR LOWER BACK PAIN	☐	HYPERTENSION/ POST PHASE III CARDIAC REHAB	☐
CANCER	☐	ARTHRITIS	☐	COPD	☐	PARKINSON'S DISEASE	☐

Relevant medical history (past and current)

PREFERRED HORIZON LEISURE CENTRE

(please tick)

HAVANT LEISURE CENTRE ☐ WATERLOOVILLE LEISURE CENTRE ☐

MEDICATION

1.	2.	3.
4.	5.	6.

Any other implications, special considerations / advice given?

DOCTOR'S OR HEALTH PROFESSIONAL'S DECLARATION

In my medical opinion, the above mentioned patient is able to undertake a suitable programme of physical activity.

SIGNATURE		PRINT NAME	
PRACTICE NAME		DATE	

PATIENT'S CONSENT

I agree to the release of medical details about me to relevant members of the Health Referral team. I understand that confidentially is assured. I am undertaking this programme on my own accord.

PATIENT SIGNATURE		DATE	

THIS REFERRAL IS ONLY VALID FOR 8 WEEKS FROM DATE OF ISSUE

Horizon

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