

Referral No: \_\_\_\_\_

**Carmarthenshire GP Exercise Referral Scheme**  
Referral Scheme Co-ordinator on 01554 747516  
**Doctors Referral Form**

Name:	_____	DOB:	_____
Address:	_____	Telephone No:	_____
	_____		
	_____		
Post code:	_____		

Doctors Name:	_____	Medical Practice:	_____
Date of Referral:	_____		

**Referral Reasons:** (please indicate all that apply)

Weight reduction	<input type="checkbox"/>	Inactive / Sedentary	<input type="checkbox"/>
Family History	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Mild depression / Anxiety / Stress	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>		
Hypertension: Medication	<input type="checkbox"/>	Diabetes: Medication	<input type="checkbox"/>
Non-Medication	<input type="checkbox"/>	Non-Medication	<input type="checkbox"/>
Other, please specify	_____		

<b>Baseline Measures:</b>	(It will help us to produce the best exercise programme if we have background information on the participant)		
Resting Heart Rate	Heart Rate Regular Yes / No	B/P Systolic	B/P Diastolic
_____	_____	_____	_____
Contraindications to Exercise: Diastolic >99    Systolic >180			
<b>Additional referral information:</b> ie medication and any other conditions not indicated previously			
_____			
_____			

<b>Initial Programme Intensity</b> (see manual for definitions)	Medium	<input type="checkbox"/>	Low	<input type="checkbox"/>
<b>Prohibited Activity</b> (please indicate if client shouldn't undertake the following):				
_____				

I refer this individual to the Carmarthenshire County Exercise Referral Scheme under the terms and conditions set out in the manual.

Signature of Referrer (GP): \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give consent to the above GP and medical practice to forward details of my medical records to the staff of the GP Exercise Referral Scheme so that an appropriate safe exercise programme can be devised for my purposes suitable to my age, ability, medical conditions and lifestyle.

I understand that only information relevant to the activities will be forwarded and that all staff involved in handling this data will have signed a confidentiality agreement and ethical agreement.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (in capitals): \_\_\_\_\_