

Lifestyle & Wellbeing Report

Referral Form

CLIENT DETAILS

Name: Mr/Ms _____ Occupation: _____

Street Address: _____ DOB: _____

Suburb: _____ Postcode: _____

Phone: (H) _____ (M) _____ (W) _____

Email: _____

Interpreter needed: Yes No Language Spoken : _____

GP DETAILS Yes, I would like a copy of my *Lifestyle & Wellbeing Report* be sent to my doctor.

Name : _____ Phone: _____ Fax: _____

Postal Address: _____

Suburb: _____ Postcode: _____

REFERRAL OPTIONS

Lifestyle & Wellbeing Report: \$99

Additionally, clients may request one or more Specialised Assessment Options from the following:

Posture-Pro V (complete digital photo postural analysis): \$33

Cholesterol-Check (complete analysis of blood fats): \$33

Cholesterol-Check is required for **males over 45 years of age** or **females over 50 years of age** who have not attended a health check (including cholesterol check) with a GP in the last 12 months.

APPOINTMENT SCHEDULING

Please complete and fax both pages of this form to (02) 9385 3195 and we will contact you to schedule an appointment at your earliest convenience.

Lifestyle & Wellbeing Report

Pre-activity Screening Questionnaire

Please complete the following questionnaire. If you are unsure about any of the questions below, please contact the Lifestyle Clinic for assistance or talk to your GP.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said that you have a heart condition OR that you should only participate in a medically supervised physical activity program ?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you feel pain in your chest when doing physical activity ?
<input type="checkbox"/>	<input type="checkbox"/>	3. In the past month, have you had chest pain when you were not doing physical activity (ie. sitting, watching television, or laying down)?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you lose your balance because of dizziness or do you ever lose consciousness ?
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have a bone or joint problem (eg. back, knee or hip) that could be made worse by a change in your physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is your doctor currently prescribing drugs (eg. fluid reduction pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you have diabetes that requires medication?
<input type="checkbox"/>	<input type="checkbox"/>	8. Do you know of any other reason why you should take precautions when doing physical activity (eg. asthma)?
<input type="checkbox"/>	<input type="checkbox"/>	9. Are you pregnant ?

If you are a **male over 45 years of age** or a **female over 50 years of age**, or you have ticked 'Yes' to any of the above questions, please indicate the estimated date of your last medical health check (including cholesterol check):- year: _____ month: _____

If you have ticked YES to any of the Questions 1 to 4, we will require you to obtain a clearance for exercise from your General Practitioner prior to undertaking the Initial Program Assessment.

If you have ticked 'Yes' to any of Q 5 to 9, your specific condition will be discussed further at the initial appointment prior to conducting assessments.

Name: _____ Signature: _____

Date: _____

We will contact you as soon as possible to arrange an initial appointment and provide you with further information regarding the program.

PLEASE FAX TO (02) 9385 3195