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| --- | --- | --- | --- | --- |
| **Referrers Details:** | | | | |
| Date of Referral: | | | Referrers Name (GP): | |
| Organisation: | | | Phone Number: | |
| Does the client consent to referral? Yes No  *FocusOne Health is a voluntary service and all clients must consent to and be willing to engage in services* | | | | |
| **Client Details:** | | | | |
| Name: | | | DOB: | |
| Gender: | Male Female Other Not stated | | | |
| Address: | | | | |
| Home Phone: | | | Mobile: | |
| Do you identify as: Aboriginal Torres Strait Islander Neither | | | | |
| Country of Birth: Australia Other (please state): | | | | |
| **What does the client wish to gain from the Healthy Habits program?** | | | | |
| **Referral criteria:**  Type II diabetes At risk of Type II diabetes BMI >30 2 of more CVD risk factorsOther | | | | |
| **Does the client have a GP Management plan:** Yes Item Number:  No  GPMP Review Date:  Chronic Disease(s):  EPC Details: | | | | |
| **Contraindications:**  Absolute: IF ALL ITEMS ARE NOT CHECKED YOUR PATIENT IS NOT SUITABLE FOR EXERCISE  No recent significant change in resting ECG, recent MI, unstable angina or uncontrolled arrhythmia  No symptomatic severe aortic stenosis, uncontrolled symptomatic heart failure, myocarditis or pericarditis  No suspected or known dissecting aneurysm, acute pulmonary embolus or infarction, acute systemic infection  Relative: THESE ITEMS ARE DISCRETIONARY IF EXERCISE BENEFITS OUTWEIGH RISKS - COMMENT IF RELEVANT  No severe hypertension (SBP>200mm Hg, DBP>110mm Hg), left main coronary stenosis, moderate stenotic heart disease  No high-degree AV block, ventricular aneurysm, hypertrophic cardiomyopathy, tachydysrhythmia or brady dysrhythmia No electrolyte abnormalities, uncontrolled metabolic disease  The GP recommends this client is suitable to participate in physical activity Yes No  Comments:  *If in doubt a specialist opinion may be necessary before participating in the program. Please note, the Healthy Habits Care Coordinator may refer back to the GP if any contraindications arise during the program.* | | | | |
| In case of Emergency contact | | Name:  Relationship to client: | | Phone: |
| Client’s Signature: Date:  GP Signature: Date: | | | | |