

# Healthy Habits Referral Form



## Participant details

Name:			
Address:			
Phone:		DOB:	
Referral date:		Gender:	
Participant identifies as Aboriginal and/or Torres Strait Islander?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Referrer details

Name:		Phone:	
Organisation:		Email:	

## Health Information

Please tick the chronic conditions or health risk factors that are relevant to you.	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart disease	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> High body weight
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Poor nutrition
<input type="checkbox"/> Other:	<input type="checkbox"/> Low physical activity

Please tick which services you are interested in:	
<input type="checkbox"/>	Group nutrition classes
<input type="checkbox"/>	Group exercise classes
<input type="checkbox"/>	Individual allied health visits (e.g. dietitian, exercise physiology)
<input type="checkbox"/>	Individual health coaching

### Pre-exercise screening

Has your medical practitioner ever told you that you have a heart condition or have you ever suffered a stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever experience unexplained pains or discomfort in your chest at rest or during physical activity/exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever feel faint, dizzy or lose balance during physical activity/exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any other conditions that may require special consideration for you to exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If you answered YES to any of the 6 questions, you will be required to seek guidance from an appropriate allied health or medical practitioner prior to undertaking exercise within the Healthy Habits program.</p>	

## GP/Health Professional Exercise Clearance

I, \_\_\_\_\_, have discussed the benefits and potential risks or discomforts of participating in an exercise program.

I agree, in conclusion with the patient, that they are suitable to participate in a low to moderate exercise assessment and supervised exercise sessions.

Please note any restrictions or considerations for exercise below: (e.g. light exercise only)

---

---

---

---

---

---

GP/Health Professional signature \_\_\_\_\_ Date \_\_\_\_\_

**Please fax completed referral form to Sonder on (08) 8252 9433 or email to [healthyhabits@sonder.net.au](mailto:healthyhabits@sonder.net.au)**