Kickstart Your Health
Referral Form

Participant details

Name:			
Address:			
Phone:		DOB:	
Referral date:		Gender:	
Participant identifies as Aboriginal and/or Torres Strait Islander?			❒ Yes ❒ No

Referrer details

Name:		Phone:	
Organisation:		Email	

Health Information

Please tick the chronic conditions or health risk factors that are relevant to you.	
❒ Diabetes	❒ High blood pressure
❒ Heart disease	❒ High cholesterol
❒ Kidney disease	❒ High body weight
❒ Osteoarthritis	❒ Poor nutrition
❒ Other:	❒ Low physical activity

Please tick the following health care arrangement/s that are applicable to you.	
❒ NDIS	❒ Concession/Pension/Health Care Card
❒ GP Management Plan	❒ Home/Aged Care Package
❒ T2DM Group Allied Health Services	❒ Aboriginal and Torres Strait Islander Health Check (715)
❒ DVA	❒ Other:

Pre-exercise screening

Question	Answer
Has your medical practitioner ever told you that you have a heart condition or have you ever suffered a stroke?	❒ Yes ❒ No
Do you ever experience unexplained pains or discomfort in your chest at rest or during physical activity/exercise?	❒ Yes ❒ No
Do you ever feel faint, dizzy or lose balance during physical activity/exercise?	❒ Yes ❒ No
Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?	❒ Yes ❒ No
If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the last 3 months?	❒ Yes ❒ No
Do you have any other conditions that may require special consideration for you to exercise?	❒ Yes ❒ No
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 Kickstart Your Health program.	

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 kickstartyourhealth@sonder.net.au