Healthy Habits
Referral Form

Referral Date	

Participant Details

First name		**Surname**	
Preferred name		**Date of birth**	
Gender		**Pronouns**	
Phone		**Email**	
Address			
Participant identifies as Aboriginal and/or Torres Strait Islander?	☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal & Torres Strait Islander ☐ No		
Participant identifies as Culturally and/or Linguistically Diverse?	☐ Yes ☐ No		
Does the participant hold a Health Care Card or Concession Card?	☐ Health Care Card ☐ Concession Card ☐ No, neither		

Referrer Details

N/A – Self-referral

Name		**Role**	
Phone		**Email**	
Organisation			

Health Information

Please tick the health conditions that are applicable to the participant	
☐ Living with heart disease	☐ Living with type 2 diabetes
☐ Difficulty managing weight	☐ Living with a mental health condition
☐ None are applicable	

Please tick the risk factors that are applicable to the participant:	
☐ History of kidney disease	☐ Family history of diabetes
☐ History of gestational diabetes	☐ Family history of heart disease
☐ Current or previous smoker	☐ Poor diet
☐ Current or history of high blood pressure	☐ Low physical activity levels
☐ Current or history of high cholesterol levels	☐ Overweight
☐ Drinking more than 10 standard alcoholic drinks per week	☐ None are applicable

Service Request

What goals does the participant need support with?	
☐ Better diet and nutrition	☐ Increased exercise
☐ Improved diabetes management	☐ Improved stress or wellbeing
☐ Alcohol cessation or reduction	☐ Smoking cessation or reduction
☐ Improved sleep	☐ Improved respiratory function
☐ Improved pain management	☐ Not sure
☐ Other:	

Pre-exercise Screening

Does the participant have a heart condition, or have they ever suffered a stroke?	☐ Yes ☐ No
Does the participant ever experience unexplained pains or discomfort in the chest at rest or during physical activity/exercise?	☐ Yes ☐ No
Does the participant ever feel faint, dizzy or lose balance during physical activity/exercise?	☐ Yes ☐ No
Has the participant experienced an asthma attack requiring immediate medical attention at any time over the last 12 months?	☐ Yes ☐ No
Does the participant have any other conditions that may require special consideration to exercise?	☐ Yes ☐ No

If you have answered YES to any of the Pre-exercise Screening questions, the participant will be required to seek guidance from an appropriate allied health or medical practitioner prior to undertaking exercise within the Healthy Habits program. Our Care Coordinator will support them to gain this clearance.

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