Adult Referral Form

PATIENT DETAILS

Full Name:
Address:
Post Code:
DOB:
Home Tel:
Mobile:
Gender:
Ethnicity:
Any Allergies:
Smoker:

GENERAL PRACTITIONER DETAILS

Referrer's Name:
Position:
Practice Name:
Address:
Preferred Centre:
Postcode:
Phone:
Email:

Start HbA1c:
Weight:
BP:
Girth:
Height:

MEDICAL CONDITIONS

Does the patient suffer, or has ever suffered from any of the following? *(Please tick all that applies)*

Asthma		Chronic Lung Disease	
Epilepsy		Stroke	
Heart Attack		Cancer	
Diabetes		PTSD	
High BP		Angina	
Atrial Fibrillation		Arthritis	

REASON FOR REFERRAL

Please provide the reason for referral below, if reason not indicated, please use the "other" box provided.

Type 2 Diabetic	
Overweight	
At risk of developing Type 2 Diabetes	
Other notes:	

REFERRER AGREEMENT

By making this referral I: _____ agree to support the patient & provide the relevant data to LGA staff in accordance to the data protection policy.

Sign: _____ Date: _____

PATIENT CONSENT

I give permission for my personal details related to the LGA programme & the details highlighted above to be disclosed to LGA staff to monitor my progress.

Sign: _____ Date: _____

Let's Get Active CIC | 11 Primrose Bank | Oldham | OL18 1HQ
07713647494 | referrals@letsgetactive.org

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Additional Information:

Guidance notes

- Please complete all relevant sections
- Recent HBA1C reading if available.
- You must ensure that the patient is suitable for the program as it involves physical activities.
- Provide any information in the additional information box that you feel will help the personal trainer to provide the best possible service to the patient

What to expect from the LGA provider:

- Confirmation of start date
- Notification if the patient fails to complete the program
- Notification if the patient is found unsuitable for the program
- Progress report on completion of the program

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