# Westminster Exercise Referral Scheme Form

Please email form to: clinical.contactcentre@nhs.net

**Please complete ALL boxes marked *. Incomplete forms will be returned to the referrer**

| 1. EXERCISE REFERRAL SITE * | |
|---|---|
| ☐ | Moberly Sports Centre, ~~Caird St, London, W10 4RR~~ |
| ☐ | Little Venice Sports Centre, Crompton St, W2 1ND |
| ☐ | Porchester Centre, Queensway, W2 5HS |
| ☐ | Paddington Recreation Ground, Randolph Ave, W9 1PD (+ sessions for mental health / learning disabilities) |
| ☐ | Queen Mother Sports Centre, Vauxhall Bridge Rd, SW1V |
| ☐ | Seymour Leisure Centre, Seymour Place, Marylebone, London, W1H 5TJ |
| ☐ | Marshall Street Leisure Centre, 15 Marshall Street, Soho, London, W1F 7EL |

Commented [BCW1]: The new address is: 25 Chamberlayne Road, London, NW10 3NB

| | 2. GP DETAILS * | 3. REFERERS DETAILS (if different) * |
|---|---|---|
| **Name of referrer** | | |
| **Job title** | | |
| **Telephone** | | |
| **Address** | | |
| **Postcode** | | |
| **Email** | | |

| 4.PARTICIPANT DETAILS * | | | |
|---|---|---|---|
| **Forename(s)** | | **Surname** | |
| **Date of Birth** | | **Age** | |
| **Gender** | | **Ethnicity** | |
| **Language** | | **Interpreter required** | Yes ☐ No ☐ |
| **Address** | | **Postcode** | |
| **Telephone** | | **NHS NO:** | |
| **Email** | | | |

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## 5. REASONS FOR REFERRAL * (Please tick all that applies)

| | |
|---|---|
| ☐ Asthma<br>Inhaler required during physical activity?<br>☐ YES ☐ NO | ☐ COPD<br>Please state level:<br>Attended Pulmonary Rehab?<br>☐ YES ☐ NO |
| ☐ Hyperlipidaemia (≥5mmol/1)<br>please state level: | ☐ Hypertension |
| ☐ Diabetes<br>please state type : | ☐ Overweight/Obesity (BMI >27) |
| ☐ Mental health condition<br>please state: Delusional disorder | ☐ Neurological condition<br>please state: |
| ☐ Musculoskeletal condition<br>please state: | ☐ NHS Health Check recommendation<br>please state reason: |
| ☐ Other: | |

## 6. PHYSICAL MEASUREMENTS *

| Blood Pressure: * | Weight: * | Height: * | BMI: * | Peak Flow: |
|---|---|---|---|---|
| | | | | |

## 7. MEDICATIONS * (Please indicate 'no medication' when none is being prescribed)

Acute Medication in the last 1 month

Repeat Medication

Allergies & Sensitivities

## 8. RELEVANT MEDICAL HISTORY / PHYSICAL LIMITATIONS / PRECAUTIONS *

Patient AIS Requirement (Accessible Information Standard)

AIS: Communication Support:

AIS: Requires Communication Professional:

AIS: Requires Specific Contact Method:

AIS: Requires Specific Information Format:

Patient Reasonable Adjustment Requirement

| 9. CONSENT * | | |
|---|---|---|
| | I, the patient, consent for any relevant personal and clinical information to be confidentially shared between my GP, ~~and the CLCH Health Improvement Team, to process my referral, and the~~ the Exercise Referral Everyone Health Team and the Westminster City Council Commissioning Team to deliver a safe programme tailored to my needs. | YES ☐ NO ☐ * |
| | I, the referrer, in my professional medical opinion, I know of no reason why the patient is unable to undertake a suitable programme of physical activity. | ☐ YES ☐ NO * |
| | **Healthcare professionals signature*** | **Date:** |
| | | |
| | | |

All information in this form will be treated confidentially and stored securely according to the General Data Protection Regulation 2018. You can withdraw your consent anytime without your rights being affected. You also have the right to raise your concerns to the Everyone Health Clinical Governance if you think there is a problem with the way we handle your data. Please email clinicalgovernance@everyonehealth.co.uk or call 0333 005 0095

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