zeroth
clinical exercise

NHS Kent and Medway

MAIDSTONE Borough Council

ADULT REFERRAL FORM

Personal Details:

Surname: _____ First name: _____

Address: _____ Post code: _____

Email: _____ Mobile: _____

Male / Female DOB: ___/___/___ Height: _____ Weight: _____ BP: _____

Current Medication:

_____

_____

_____

_____

Relevant Medical History:

_____

_____

_____

_____

REASON FOR REFERRAL	X	REASON FOR REFERRAL	X
Weight for Life		Hypercholesterolemia	
Diabetes Mellitus		Hypertensive	
Sedentary Lifestyle		Smoker	
Musculoskeletal Disorders		Post Natal Exercise	
Cancer (state type)		Neurological Condition	
Depression		Strong Family History of CHD	
Learning Difficulties		CHD	
CVA/TIA		PVD	
COPD		Other (please state)	
Obesity - BMI over 28			

The above named person is capable of participating in an exercise programme under the guidance and supervision of an exercise instructor at Zeroth Clinical Exercise Centre.

Medical Professional (Print) : _____

Signature: _____ Date: ____/____/____

Email: _____

Practice Hospital/Address: _____

Post Code: _____ Contact Number: _____

Patient Informed Consent

The Zeroth programme has been fully explained to me. I am prepared to participate and give my consent for any relevant clinical information to be transferred to the exercise professional. I consent to this information being stored on a database

Signed: _____ Parent/Guardian

Print Name: _____ Date: _____

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