Before referring a patient into the Exercise Referral Scheme, please ensure that their condition makes them a suitable candidate by referring to the table below:

|  |
| --- |
| **Suitable for Referral - Information for referee** |
| **All referrals must be:**   * **Aged 17+** * **Considered inactive** not moderately active for a total of thirty minutes more than twice a week * Suffer from mild to moderate rheumatoid arthritis or osteoarthritis * Suffer from mild to moderate depression, stress or anxiety * Suffer with a condition that impedes mobility * Recently diagnosed with cancer or rehabilitating * Obesity/Overweight (BMI 25+) * Controlled/stable diabetes   **Exhibit at least one risk factor for coronary heart disease / osteoporosis**   * Smoking * Family history of heart disease * High cholesterol levels (consistently above 5.0mmol/L or 6.2mmol/L total cholesterol) * Waist circumference above 37” men and 32” women * Hypertension stable below 180/110mmHg or 140/90 to 179/109 mmHg * Heavy alcohol consumption * Hysterectomy * Taking prescribed corticosteroids * Early menopause * History of amenorrhea |
| **Not suitable for Referral** |
| * Severe ischemic heart disease * Uncontrolled health conditions insulin dependent diabetes * Severe or poorly controlled asthma * Unstable or severe mental health state * Cardiac Event or General Surgery, within last 12 months (such individuals may be referred at the Healthcare Professionals discretion with supporting letter) * Patients who are in Healthcare Professionals opinion are not medically fit to undertake an exercise programme |

**It is important you follow the referral procedure as closely as possible in order to ensure your patient is dealt with promptly. At the end of your appointment with a patient please ensure that you have followed procedure. Please check the criteria below and tick all the boxes before submitting the referral**

|  |  |
| --- | --- |
|  | **The patient being referred is suitable to undertake a physical activity programme in accordance with the guidelines above** |
|  | **The patient understands that they are being referred to the Active MK Exercise Referral scheme for a 12 week period** |
|  | **The patient understands that the scheme is not free and there is a small charge for sessions** |
|  | **The patient agrees to give their consent for relevant clinical information regarding their health and participation to be used for monitoring purposes and to action the referral** |

**Data Protection Privacy Statement**

We collect and use information about you so that we can provide you with health & wellbeing services for public interest basis. You have the right to withdraw your consent at any time. Doing so may mean we are unable to provide the service you are hoping to receive and the implications of you giving or withdrawing your consent will be explained at the time. Full details about how we use this data and the rights you have around this can be found at <https://www.milton-keynes.gov.uk/social-care-and-health/adult-social-care/privacy-notice-adult-services-milton-keynes-council> If you have any data protection queries, please contact the Council Data Protection Officer at [data.protection@milton-keynes.gov.uk](mailto:data.protection@milton-keynes.gov.uk)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referrers Details**  **Referrers Job Title:\*** |  | **Referrers Name:\*** |  | |
| **Referring Organisation:** | <Sender Details> | **Date Referred:** | <Todays date> | |
| **Patients GP:** | <GP Name> | **Re-referral (please tick)**) |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | | | | | | | | | | | | | | |
| **Full Name:\*** | <Forename> <Surname> | | | | | | **Address:\*** | | | <Patient Address> | | | | |
| **Gender:** | <Gender> | | | | | |  | | |
| **DoB**:\* | <Date of Birth> | | | | | |  | | |
| **Tel No:** | <Patient Contact Details> | | | | | |  | | |
| **Ethnicity:\*** | <Ethnicity> | | | | | | **Postcode:\*** | | | <Patient Postcode> | | | | |
|  | | | | | | | | | | | | | | |
| **Medical Information** | | | | | | | | | | | | | | |
| **Pre BMI:\*** | | <Latest BMI> | | | **Primary Medical Conditions (please tick appropriate boxes):** | | | | | | | | |  |
| **Pre Resting HR:** | | <Numerics> | | |  | | | | | | | | | |
| **Pre Waist Circ:** | | <Numerics> | | |  | Cancer Rehab | | | | |  | Diabetes Type 1 | | |
| **Pre BP Systolic:\*** | | <Numerics> | | |  | Cancer Prehab | | | | |  | Diabetes Type 2 | | |
| **Pre BP Diastolic:\*** | | <Numerics> | | |  | Raised Cholesterol | | | | |  | Depression | | |
|  | |  | | |  | Moderate Hypertension | | | | |  | Stable Angina | | |
|  | |  | | |  | Smoking Related | | | | |  | Controlled COPD | | |
|  | |  | | |  | Impaired Strength Mobility | | | | |  | Back Problem | | |
|  | |  | | |  | Overweight | | | | |  | Cardiac Referral | | |
| **Physical Referral Information** | | | |  |  | Stroke | | | | |  | Asthma | | |
| **Pre Activity Level:\*** | | |  | | | | | | | | | | | |
| **Current Medication** | | | Other | | | | | | | | | | | |
| **Mobility Needs :** | | |  | Wheel Chair | | | |  | Walking Aids | | | |  |  |
| **Do you consider yourself to**  **have a disability?: Yes/ No**  **Please specify** | | |  | | | | | | | | | | | |
| **Additional patient information (e.g. inappropriate exercise)** | | |  | | | | | | | | | | | |

Participants Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participants email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_