**Patient consultation form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Learner name:** |  | **Date:** |  |

|  |  |
| --- | --- |
| Patients name: |  |

|  |
| --- |
| **Information required from patient prior to consultation (please tick as appropriate)** |
| Referral form attached |  |
| Transfer medical records attached |  |
| Risk stratification records attached |  |
| **Medical and lifestyle information**  |
| **Medical and surgery history** | **Medications** |
|  |  |
| **Physical activity history** | **Physical activity preferences** |
|  |  |
| **Motivation and barriers to participation** | **Current fitness level** |
|  |  |
| **Stage of readiness** | **Personal behavioural goals** |
|  |  |
| **Physical measurements**  |
| Height |  | Weight |  |
| Blood pressure |  | Heart rate |  |
| BMI |  | Waist circumference |  |

|  |
| --- |
| **Patients short, medium and long-term goals**  |
| Medical management | General health and fitness | Physiological | Psychological |
|  |  |  |  |
| Lifestyle | Social | Functional ability |
|  |  |  |
| Patients signature |  | Date: |  |
| *\*an electronic signature is acceptable for this document* |
|  |  |

**Exercise referral transfer form**

An Exercise Referral Transfer form will need to be provided by the scheme referring the patient. If you are working with a patient that has not been referred to you via the referral scheme you will need to complete a referral transfer form for this case study. You will find an example of an exercise referral transfer form below.

* If you working with a referred patient: You can copy and paste a JPEG (photo) of the referral form into the space below this statement.

**Insert a Copy of the referral form here:**

* If you are working with a patient that has NOT been referred: You can use the example referral form below. If you patient has not been referred you will need to add a copy of the patients’ PAR-Q. Please see below for an example you can use.

**Exercise referral transfer form**

**PHYSICAL ACTIVITY/EXERCISE REFERRAL TRANSFER FORM**

**Physical activity referral is one way of increasing physical activity levels of patients with specific medical conditions.**

**It may not be the most appropriate route for patients where there is no underlying medical conditions or risk.** A general recommendation to increase physical activity levels in order to gain health benefits may be all that is required if you consider the patient has reasonable motivation and resources to safely increase their physical activity levels.

**Refer to the scheme inclusion criteria and use your professional judgement to determine whether the exercise referral scheme is the most appropriate route for the patient.**

**PLEASE COMPLETE THIS FORM IF THE PATIENT IS BEING REFERRED**

To be completed by the Referring Practitioner ONLY

***Please complete all sections of the form, incomplete forms may be returned and your patient may be temporarily deferred until all relevant medical information is obtained.***

|  |  |
| --- | --- |
| **Patient details** | **Referring practitioners details** |
| **Surname** |  | **Name** |  |
| **Forename** |  | **Position** |  |
| **Male/female** |  | **Address** |  |
| **Date of birth** |  |
| **Address** |  |
| **Tel No.** |  |
| **Fax No.** |  |
| **Contact Tel No.** |  | **Email address** |  |
| **NHS No.** |  | **Referral No.** |  |
| **Registered GP details:** Please check against scheme inclusion/exclusion criteria |
| **Name** |  | **Address** |  |
| **Practice** |  |  |
| **Tel No.** |  |  |
| **Fax No.** |  |  |
| **Email address** |  |  |  |
| **Reason for referral (**Insert list of conditions included in the scheme if preferred) |
|  |
| **Medical Information:** Please provide all relevant information about the patient’s health status |
| **Resting HR** |  | **Systolic BP:** |  | **Diastolic BP:** |  | **BMI** |  |
| **Medical conditions:** Please give details of all relevant current and past health problems |
| **Details:** | **Dates:** |
| **Medication:** **Please provide a list of any medications being taken**  | **Physical limitations:** **Please provide details of any physical limitations** |
| **i.e. Beta blockers** | **e.g. Arthritis of the hip** |
| **Additional relevant information:** Please include any additional relevant information which has not been included in other parts of this form. |
| **e.g. awaiting further investigations** |
| **Patient Consent** The exercise referral scheme has been fully explained to me. I am prepared to participate and I give my permission for this information to be passed to staff on the physical activity referral scheme.  |
| Please print your name: |  |
| Signature of patient: |  |
| Date: |  |
| Important: This referral is valid for 3 months. If the patient fails to attend the initial consultation within 3 months of the date of referral and still wishes to participate in the referral scheme, the patient must see the Referring Practitioner in order to be re-referred.Physical activity Officers are advised NOT TO ACCEPT responsibility for a referred patient until all relevant clinical information is confirmed and signed.Referral letters or forms without this information or containing only blanket phrases such as I know of no reason why Mrs X should not engage in exercise **are not acceptable as part of a quality referral system.** |

|  |
| --- |
| **Transfer medical records:** Please include any additional relevant information which has not been included in other parts of this form. |
|  |

**PAR Q**

A physical activity readiness questionnaire for people aged 15 to 69

Being more active is very safe for most people. However, some people should check with their doctor before they start becoming more physically active.

If you are planning to become more physically active than you are now, start by answering the questions below. If you are between the ages of 15 and 69, the PAR q will tell you if you should check with your doctor before you start being more active. If you are over 69 years of age, and you are not used to being very active, you should check with your doctor before you start any new activity.

Please read the questions and answer each one YES or NO

|  |
| --- |
| 1. Has your doctor ever said that you have a heart condition and that you should only do

 physical activity recommended by a doctor? YES NO 1. Do you feel pain in your chest when you do physical activity? YES NO
2. In the past month, have you had chest pain when you are not doing physical activity? YES NO
3. Do you lose your balance because of dizziness or do you ever lose consciousness YES NO
4. Do you have a bone or joint problem (for example, back, knee or hip) that could be made

 worse by a change in your physical activity? YES NO 1. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure

 or heart condition? YES NO1. Do you know of any other reason why you should not take part in physical activity? YES NO
 |

**If you answered YES to one or more questions.**

**You must talk with your doctor BEFORE you start to become more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR Q and which questions you answered YES.**

* You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities which are safe for you. Talk to your doctor about the type of activity you wish to participate in and follow his/her guidance.
* Find out which community programs are safe and helpful for you.

**If you answered NO to all the questions.**

**If you answered NO honestly to all PAR Q questions, you can reasonable sure that you can:**

* Start becoming more physically active – begin slowly and build up gradually. This is the safest and easiest way to go,
* Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If you reading is over 144/94, talk with your doctor before you start becoming physically active.

**Delay becoming more active:**

* If you are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better; or
* If you are or may be pregnant – talk to your doctor before you start to become more active.

**Please note:** If your health changes so that you then answer YES to any of the above questions, tell you fitness or health professional. Ask whether you should change your physical activity plan.

Note: if the PAR Q is being given to a person before he/she participates in a physical activity programme or a fitness appraisal, this section may be used for legal or administrative purposes.

‘I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction’

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  |  | Date: |  |
| Signature: |  | Date: |  |
| Signature of parent or guardian: |  |
| Witness: |  |

|  |
| --- |
| **Note: This physical activity clearance is only valid for 12 months from the date it is completed and become invalid if your condition changes so that you would answer YES to any of the seven questions.** |

**Risk stratification**

Identify the level of risk on the Irwin and Morgan tables below and include a short sentence to state what risk your client is (Low to Medium only – the learner cannot use a high risk client)

|  |
| --- |
| **Low Risk – People with minor, stable physical limitations or 2 or less CHD factors**  |
| Overweight | No complications |
| High normal BP | (130-139/85-89) not medicated |
| Type 2 diabetes | Diet controlled |
| Reconditioned | Due to age or inactivity |
| Older people aged > 65 | No more than 2 CHD risk factors and not at risk of falls |
| Antenatal | No symptoms of pre-eclampsia / no history of miscarriage |
| Postnatal | Provided 6/52 week check complete and no complications |
| Osteoarthritis | Mild where physical activity will provide symptomatic relief |
| Mild bone density changes | BMD > 1 and < 2.5 SD young adult mean  |
| Exercise Induced asthma | Without other symptoms |
| Smoker | One other CHD risk factor and no known impairment of respiratory function  |
| Stress/mild anxiety |  |
| Seropositive HIV | Asymptomatic |

|  |
| --- |
| **Medium Risk – People with significant physical limitations related to chronic disease or disability** |
| Hypertension Stage 1 | (140-159/90-99) Medication controlled |
| Type 2 diabetes | Medication controlled |
| Type 1 diabetes | With adequate instructions regarding modification of insulin dosage depending on timing of exercise and warning signs |
| Physical disabilities | No other risk factors |
| Moderate OA /RA | With intermittent mobility problems |
| Clinical diagnosis Osteoporosis | BMD – 2.5 at spine, hip or forearm or > 4 on fracture index, with no history of previous low trauma fracture |
| Surgery – Pre and Post  | General or Orthopaedic. NOT CARDIAC |
| Intermittent claudication | No symptoms of cardiac dysfunction |
| Stroke / TIA | > 1 year ago. Stable CV symptoms. Mobile no assistance required |
| Asthma | Mild (respiratory limitation does not restrain submaximal exercise) |
| COPD | Without respiratory limitation but would benefit from optimisation of respiratory system mechanics and improvement of physical de-conditioning |
| Neurological conditions | Young onset Parkinson’s Disease (stable); Multiple Sclerosis |
| Early symptomatic HIV | Moderately diminished CD4 cells, intermittent or persistent signs and symptoms e.g., fatigue, weight loss, fever, lymphadenopathy |
| Chronic Fatigue Syndrome | Significantly de-conditioned due to longstanding symptoms |
| Depression | Mild or moderate |
| Fibromyalgia | Associated impaired functional ability, poor physical fitness, social isolation, neuroendocrine and autonomic system regulation disorders |

|  |
| --- |
| **High Risk – People with current severe disease or disability. Not suitable for Exercise Referral Schemes** |
| Older people > 65 years at risk of falls. Frail older people with Osteoporosis and history of fracture | REFER DIRECT TO FALLS SERVICE (BMD > -2.5 at spine, hip or forearm in the presence of one or more documented low trauma or fragility fractures) REFER DIRECT TO FALLS SERVICE |
| Unstable and uncontrolled cardiac disease |  |
| Claudication with cardiac dysfunction |  |
| Orthostatic hypotension | Fall SBP >20mg/Hg or DBP > 10 mg/Hg within 3 mins of standing |
| Stoke / TIA | Recent (>3 months ago) |
| Severe OA / RA | With associated immobility  |
| Type 1 or Type 2 Diabetes (Advanced)  | With accompanying autonomic neuropathy, advanced retinopathy |
| Moderate to severe Asthma | Where respiratory limitation restrains sub maximal exercise |
| COPD / Emphysema | With true respiratory limitation |
| AIDS | With accompanying neuromuscular complications, severe depletion of CD4 cells, malignancy or opportunistic infection  |
| Psychiatric illness / cognitive impairment / dementia | AMT score < 8 |

|  |
| --- |
| **Risk stratification statement**  |
| Client name: |
| (Insert your statement here) |

**Exercise referral programme 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients name:** |  | **Date:** |  |
| **Learner name:** |  | **Date:** |  |

|  |
| --- |
| **Week no 1:**  |
| Recommended exercise activity (1) | Recommended exercise activity (2) | Recommended exercise activity (3) |
|  |  |  |
| Description of environment | Description of environment | Description of environment |
|  |  |  |
| Safety/Environmental considerations (1) | Safety/Environmental considerations (2) | Safety/Environmental considerations (3) |
|  |  |  |
| Frequency |  | Frequency |  | Frequency |  |
| Intensity |  | Intensity |  | Intensity |  |
| Time  |  | Time |  | Time |  |
| **Weekly goals** |
|  |
| **Description of any equipment uses** |
|  |

**Session plan 1**

|  |  |
| --- | --- |
| Learner name: |  |

|  |  |
| --- | --- |
| **Condition 1** | **Condition 2** |
|  |  |
| Purpose of session: | Duration of session: | Resources required: |
|  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Warm up** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Main session** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Cool down** |  |  |  |

**Exercise referral programme 2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients name:** |  | **Date:** |  |
| **Learner name:** |  | **Date:** |  |
|  |  |  |  |
| **Week no 2:**  |
| Recommended exercise activity (1) | Recommended exercise activity (2) | Recommended exercise activity (3) |
|   |  |  |
| Description of environment | Description of environment | Description of environment |
|  |  |  |
| Safety/Environmental considerations (1) | Safety/Environmental considerations (2) | Safety/Environmental considerations (3) |
|  |  |  |
| Frequency |  | Frequency |  | Frequency |  |
| Intensity |  | Intensity |  | Intensity |  |
| Time |  | Time |  | Time |  |
| **Weekly goals** |
|  |
| **Description of any equipment uses** |
|  |

**Session plan 2**

|  |  |
| --- | --- |
| Learner name: |  |

|  |  |
| --- | --- |
| **Condition 1** | **Condition 2** |
|  |  |
| Purpose of session: | Duration of session: | Resources required: |
|  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Warm up** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Main session** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Cool down** |  |  |  |

**Exercise referral programme 3**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients name:** |  | **Date:** |  |
| **Learner name:** |  | **Date:** |  |
|  |  |  |  |
| **Week no 3:**  |
| Recommended exercise activity (1) | Recommended exercise activity (2) | Recommended exercise activity (3) |
|   |  |  |
| Description of environment | Description of environment | Description of environment |
|  |  |  |
| Safety/Environmental considerations (1) | Safety/Environmental considerations (2) | Safety/Environmental considerations (3) |
|  |  |  |
| Frequency |  | Frequency |  | Frequency |  |
| Intensity |  | Intensity |  | Intensity |  |
| Time |  | Time |  | Time |  |
| **Weekly goals** |
|  |
| **Description of any equipment uses** |
|  |

**Session plan 3**

|  |  |
| --- | --- |
| Learner name: |  |

|  |  |
| --- | --- |
| **Condition 1** | **Condition 2** |
|  |  |
| Purpose of session: | Duration of session: | Resources required: |
|  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Warm up** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Main session** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Cool down** |  |  |  |

**Exercise referral programme 4**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients name:** |  | **Date:** |  |
| **Learner name:** |  | **Date:** |  |
|  |  |  |  |
| **Week no 4:**  |
| Recommended exercise activity (1) | Recommended exercise activity (2) | Recommended exercise activity (3) |
|   |  |  |
| Description of environment | Description of environment | Description of environment |
|  |  |  |
| Safety/Environmental considerations (1) | Safety/Environmental considerations (2) | Safety/Environmental considerations (3) |
|  |  |  |
| Frequency |  | Frequency |  | Frequency |  |
| Intensity |  | Intensity |  | Intensity |  |
| Time |  | Time |  | Time |  |
| **Weekly goals** |
|  |
| **Description of any equipment uses** |
|  |

**Session plan 4**

|  |  |
| --- | --- |
| Learner name: |  |

|  |  |
| --- | --- |
| **Condition 1** | **Condition 2** |
|  |  |
| Purpose of session: | Duration of session: | Resources required: |
|  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Warm up** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Main session** |  |  |  |
|  | Exercise Activity (including sets, reps, time, intensity) | Safety points | Adaptations/ progressions |
| **Cool down** |  |  |  |

**Patient review questionnaire**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name: |  | Date: |  |

Reason for review (to be completed by instructor)

|  |  |  |
| --- | --- | --- |
| **Question for patient** | **Patient response** | **Details of any action to be taken (to be completed by instructor)** |
| 1. How easy has it been to find time to follow the exercise programme
 |  |  |
| 1. Would you like me to change any of the activities I have suggested
 |  |  |
| 1. Have there been any significant changes in your lifestyle since we last spoke, if so please give details?
 |  |  |

|  |  |  |
| --- | --- | --- |
| **Question for patient** | **Patient response** | **Details of any action to be taken (to be completed by instructor)** |
| 1. Please tell me how close you feel you are to achieving each of the following goals which we set (goals to be inserted by the instructor)
 |  |  |
| a) |  |  |
| b) |  |  |
| c) |  |  |
| d) |  |  |

|  |  |  |
| --- | --- | --- |
| **Question for patient** | **Patient response** | **Details of any action to be taken (to be completed by instructor)** |
| 1. Which of the exercises do you feel are the most challenging?
 |  |  |
| 1. Which of the exercises do you feel are the least challenging
 |  |  |
| 1. Please indicate any activities, resources or environments you would like to be changed from those originally agreed?
 |  |  |
| 1. I am planning to introduce some adaptations to you current programme

Do you have any objections? |  |  |

**Adaptations to programme**

|  |  |  |  |
| --- | --- | --- | --- |
| Patients name: |  | Date: |  |
| Learner name: |  | Date: |  |
|  |  |  |  |
| **Week no 1:**  |
| Recommended exercise activity (1) | Recommended exercise activity (2) | Recommended exercise activity (3) |
|   |  |  |
| Description of environment | Description of environment | Description of environment |
|  |  |  |
| Safety/Environmental considerations (1) | Safety/Environmental considerations (2) | Safety/Environmental considerations (3) |
|  |  |  |
| Frequency |  | Frequency |  | Frequency |  |
| Intensity |  | Intensity |  | Intensity |  |
| Time |  | Time |  | Time |  |
| **Weekly goals** |
|  |
| **Description of any equipment uses** |
|  |

**Patient exercise guidelines assessment checklist**

|  |  |
| --- | --- |
| **The Learner has:** |  **Outcome** |
| Initial Assessment | Re-assessment |
| G1: planned specific outcome measures, stages of achievement and exercises/physical activities that are:* Appropriate to patients’ medical condition/s, goals and level of fitness
 |  |  |
| G2: ensured appropriate components of fitness are built into the programme |  |  |
| G3: applied the principles of training which are appropriate to exercise referral patients and their condition/s to help achieve, short, medium and long terms goals |  |  |
| G4: described a range of resources required to deliver exercise referral programmes for individuals and groups, including:* Environment for the session
* Portable equipment
* Fixed equipment
 |  |  |

Final result: Pass Refer

|  |  |  |  |
| --- | --- | --- | --- |
| Learner’s signature: |  | Date: |  |
| *\*an electronic signature is acceptable on this document* |
| Assessor’s signature: |  | Date: |  |
| *\*an electronic signature is acceptable on this document* |
| IAQ’s signature: |  | Date: |  |

Patient review assessment checklist

|  |  |
| --- | --- |
| **The learner has:** | **Outcome** |
| Initial assessment | Re assessment |
| A1: monitored patients’ progress using appropriate methods |  |  |
| A2: explained the purpose of reviewing progress to patients |  |  |
| A3: kept accurate record of reviews and their outcome |  |  |
| A4: recorded changes to programme plans to take account of adaptations |  |  |
| A5: monitored the effectiveness of exercise referral as necessary |  |  |
| A6: monitored integration of exercise referral programme and wider physical activity (see review questionnaire Q1) |  |  |
| A7: provided alternatives to the programmed exercise/physical activities if patients cannot take part as planned (see review questionnaire Q2) |  |  |
| A8: review short, medium and long terms goals with patients at agreed points in programme, taking into account any changes in circumstances (see review questionnaire Q3) |  |  |
| A9: encouraged patients to give their own views on progress (see review questionnaire Q4) |  |  |
| A10: used suitable methods of evaluation that will help to review patient progress against goal’s and initial baseline data (see review questionnaire Q4) |  |  |
| A11: identified goals and exercise/physical activities that need to be redefined or adapted (see review questionnaire Q5 & Q6) |  |  |
| A12: identified and agreed any changes to resources and environments with the patient (see review questionnaire Q7) |  |  |
| A13: provided alternatives to the programmed exercise/physical activities if patients cannot take part as planned (see review questionnaire Q7) |  |  |
| A14: introduced adaptations in a way that is appropriate to patients, their needs and medical conditions (see review questionnaire Q8) |  |  |
| A15: gave feedback to patients during their review that is likely to strengthen their motivation and adherence |  |  |
| A16: agreed adaptations, progressions or regressions to meet patients’ needs to optimise achievement (see review questionnaire Q8) |  |  |
| A17: agreed review outcomes with patients and other professionals where necessary (see review questionnaire Q8) |  |  |

**Letter to healthcare professional**

*(Instructor to insert letter to healthcare professional here)*

Letter to healthcare professional assessment checklist

|  |  |
| --- | --- |
| **The learner has written a letter to a healthcare professional communicating:**  | **Outcome** |
| Initial assessment | Re assessment |
| Appropriate information |  |  |
| Using accurate language |  |  |

Final result: Pass Refer

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Learner’s name: |  | Signature: |  | Date: |  |
| Assessor’s name: |  | Signature: |  | Date: |  |
| IQA’s name: |  | Signature: |  | Date: |  |

**Candidate statement:**

The submission of any worksheet or plans or case study material must be the work of you (the student). Should you chose to share the delivery of your workplace sessions the work submitted here must be entirely your own. The assessment and internal quality assurance teams at YMCAfit audit candidates' work thoroughly and should any concerns arise all parties will be subject to thorough investigation, which will be taken up by the awarding body.

Diploma in Exercise Referral candidate statement

I confirm the information submitted is entirely my own work.

|  |  |  |  |
| --- | --- | --- | --- |
| Candidate signature: |  | Date: |  |

**Participant statement:**

As a participant in this Diploma in Exercise Referral case study you may be contacted by YMCAfit to further authenticate the candidate work. Please complete the information below.

Diploma in Exercise Referral participant statement

I consent to my information being used for the purposes of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(insert student name) Diploma in Exercise Referral case study.

I understand that I may be contacted by YMCAfit to confirm my consent to participation and answer questions to authenticate the programme.

|  |  |
| --- | --- |
| Participant Name:  |  |
| Participant Signature: |  |
| Tel No. |  |
| Date: |  |

**Assessor feedback sheet**

|  |  |  |  |
| --- | --- | --- | --- |
| **Learner’s Name:** |  | **Assessor’s Name:**  |  |

|  |  |
| --- | --- |
| **Question number** | **Assessor feedback** |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Final Result:** |  | Pass |  | Fail  |
| Learner’s signature: |  | Date: |  |
| *\*an electronic signature is acceptable on this document* |
| Assessor’s signature: |  | Date: |  |
| *\*an electronic signature is acceptable on this document*  |
| IAQ’s signature: |  | Date: |  |
| *\*an electronic signature is acceptable on this document* |