

**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**

**The case study replicates the process of the Exercise Referral Instructor receiving a referral patient, completing a consultation and planning and implementing their patients program. This resource has been designed to help you complete the case study successfully – we hope it helps!**

Fill in your name, date (of consultation) and patients name at the top of the page and tick the 3 boxes in the information required section once all 3 pieces of information have been completed. Templates for these records can be found later in the case study.

Ensure all sections are complete here giving as much detail as possible, you can expand the boxes if needed.  
Information on conducting a consultation can be found in chapters 4 and 5 of your learner manual.

Ensure all boxes are complete here.

Medical management	General health and fitness	Physiological	Psychological
Lifestyle	Social	Functional ability	

You must ensure you use the information gathered from your client so far to establish short, medium and long term goals for at least three of the following aspects. It's usually easiest to establish a long term goal and work backwards, setting short and medium term goals that build towards the long term

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.

If you're working with a real life referral client you can insert the referral transfer letter you received here. If you're client is hypothetical you can complete the example form on the next page.

## 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.

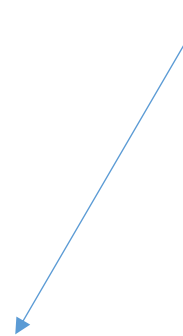
PLEASE COMPLETE THIS FORM IF THE PATIENT IS BEING REFERRED

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			

All boxes in these two sections need to be completed.



<b>Tel No.</b>			
<b>Fax No.</b>			
<b>Email address</b>			
<b>Reason for referral</b> (Insert list of conditions included in the scheme if preferred)			
<b>Medical Information:</b> Please provide <u>all relevant</u> information about the patient's health status			
<b>Resting HR</b>		<b>Systolic BP:</b>	
		<b>Diastolic BP:</b>	
		<b>BMI</b>	
<b>Medical conditions:</b> Please give details of <u>all relevant current and past</u> health problems			
<b>Details:</b>		<b>Dates:</b>	
<b>Medication:</b> Please provide a list of <u>any medications being taken</u>		<b>Physical limitations:</b> Please provide details of <u>any physical limitations</u>	
i.e. Beta blockers		e.g. Arthritis of the hip	
<b>Additional relevant information:</b> Please include any additional relevant information which has not been included in other parts of this form.			
e.g. awaiting further investigations			
<b>Patient Consent</b>			

Here you must give at least two of the 15 conditions that fall under an exercise referral instructor's scope of practice.

Complete all boxes in the medical information section.

Here provide details of ALL past and present medical conditions/health problems.

Medication: list current medication details.  
Physical limitations: list any physical limitations the patient has, these may or may not be the result of one of their conditions.

Include any relevant additional information that hasn't been covered so far.

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.

'Patient' to print, sign and date.

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

If patient has declared something and you need further evidence, for example requesting medical records from previous doctors or physio.

# 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 <u>physical</u> activity recommended by a doctor?     | YES | NO |
| 2. Do you feel pain in your chest when you do physical activity?   | YES | NO |
| 3. In the past month, have you had chest pain when you are not doing physical activity?  | YES | NO |
| 4. Do you lose your balance because of dizziness or do you ever lose consciousness   | YES | NO |
| 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made <u>worse</u> by a change in your physical activity? | YES | NO |
| 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure <u>or</u> heart condition?                    | YES | NO |
| 7. Do you know of any other reason why you should not take part in physical activity?  | YES | NO |

Delete YES or NO as appropriate and make sure that all information in the bottom is signed and dated.

### 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: \_\_\_\_\_



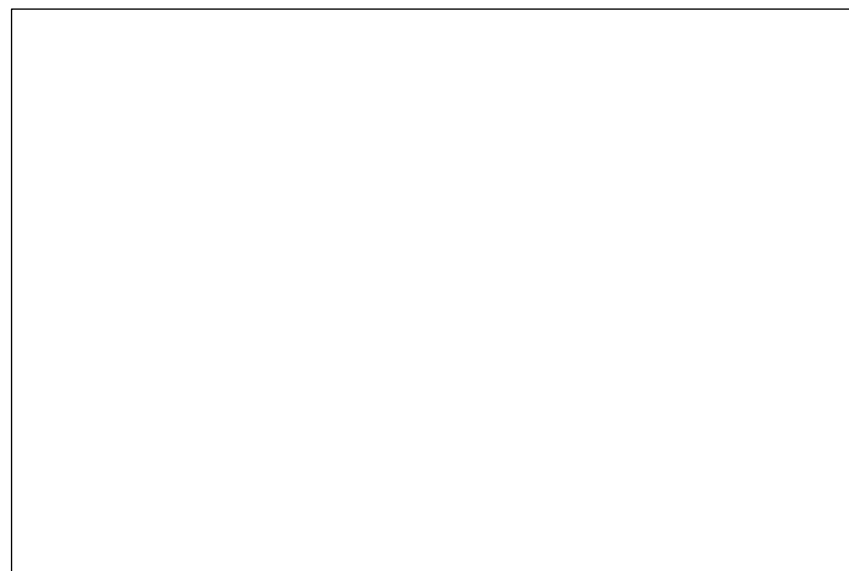
## Risk stratification

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

Information on risk stratification can be found on pages 72 and 73 of your learner manual.

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 $\geq 4$ 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)

Here explain and justify the level of risk you have indicated.

## 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					

You now need to plan a 4 week progressive programme that work towards the goals you have set for your client. You will then need to plan an exercise session for each of the 4 weeks.

Complete patient and learner details at top.

Give the main activities you recommend for the first week – a minimum of 2 are required.

Describe the environment you want your client to complete each activity.

Give the safety and environmental considerations for each recommended activity.

Frequency: how many times per week they should complete activity

Intensity: % of MHR or RPE they should aim to work at. This could also be % or 1RM for resistance work.

Time: length of time client should spend doing activity in one session.

Weekly goals can include specific session goals or they could be lifestyle based such as walking to work instead of driving.

Describe any equipment that is to be used in the above activities

## 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			

State the two conditions your client has.

Purpose of session: give some general aims of the session i.e. what components of fitness you want to work on.

Resources required: give any 'non gym' equipment that may be required for the session e.g. HR monitor.

Exercise/activity: here plan the exercises/activities that your client will complete for each section

Safety points: here give safety points/considerations for each activity that may relate to your clients conditions.

Adaptations/progressions: in this column give an option of how you could adapt the exercise for the client if they are having difficulties, possibly due to their condition.

Complete all four programmes and session plans ↓

## 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					

### 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		
2. Would you like me to change any of the activities I have suggested		
3. Have there been any significant changes in your lifestyle since we last spoke, if so please give details?		

Once your patient has completed their 4 week programme you need to complete the patient review questionnaire.

Provide details of the responses of your patient's responses/answers to each question.

In the last column give details of any actions, alterations or adaptations you will make in response your patients answer.

Question for patient	Patient response	Details of any action to be taken (to be completed by instructor)
4. 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)
5. Which of the exercises do you feel are the most challenging?		
6. Which of the exercises do you feel are the least challenging		
7. Please indicate any activities, resources or environments you would like to be changed from those originally agreed?		
8. 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					

Fill out patient and learner details at top.

Based on the information provided by your client in the patient review questionnaire, plan any adaptations you intend to make to the programme. Complete all sections for each adaptation.

## 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: <ul style="list-style-type: none"> <li>• Appropriate to patients' medical condition/s, goals and level of fitness</li> </ul>		
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: <ul style="list-style-type: none"> <li>• Environment for the session</li> <li>• Portable equipment</li> <li>• Fixed equipment</li> </ul>		

To be completed by your assessor.

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)*

Here you need to compose a letter to the referring health care professional giving details of the patient's progress in meeting the goals you set in the consultation.

Ensure the letter contains specific information and uses professional language.

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: \_\_\_\_\_

IOA'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: \_\_\_\_\_

Read the statement then sign and date.

If your patient was real they need to read the statement and complete the details below.

## 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*