Cambrian Community Gym

Exercise and Wellbeing Referral: Eligibility and Referral Form

The Cambrian Community Gym's Exercise Referral Scheme is a great way of increasing the physical activity levels of patients with specific medical conditions. We provide medically tailored, supervised exercise sessions and can also provide patients with information on additional services specific to their medical needs; once referred we will discuss these options/ pathways with your patient. Our programme will help individuals to self manage their condition(s) more effectively and with more confidence.

Inclusion Criteria:

1 Richmond resident aged 18+ and/or registered with a GP in Richmond
2 Physically inactive (< 30mins moderate intensity exercise per week)

Have at least one of the following chronic medical conditions:

1 Hypertension
2 Hyperlipidaemia
3 Mild to moderate mental health (depression/anxiety or stress)
4 Diabetes Type 1 and 2 (controlled)
5 Fibromyalgia/ Chronic Fatigue Syndrome
6 Musculoskeletal conditions (including osteoporosis and arthritis)
7 Asthma
8 Peripheral arterial disease
9 Stroke (post specialist rehabilitation programme)
10 Cancer (post specialist rehabilitation programme)
11 Cardiovascular disease (post specialist rehabilitation programme)
12 COPD (post specialist rehabilitation programme)
13 Long Covid Syndrome (post specialist rehabilitation programme)

Exclusion Criteria:

- Adults who live outside of Richmond's geographic boundary
- Pregnant women
- Need a rehabilitation exercise programme tailored to support recovery from specific conditions including: Cardiac Rehabilitation, Stroke, Pulmonary Rehabilitation, Neuromuscular Disease
- Unstable or uncontrolled medical conditions
- Unstable/uncontrolled moderate or severe mental health condition
- Participants with contraindications for exercise according to current British Association for Cardiovascular Prevention and Rehabilitation (BACPR) guidelines.

If you have a patient who does not fit into these criteria but you feel that they could benefit from participating in our exercise referral scheme, please contact us and we can discuss whether or not it is an option for them and how best we can support them.

Our instructors will contact the referring health professional if we require further advice or clarification on any medical condition or medication.

Please send any completed forms via Egress to

referrals@cambriancentre.org

or by post directly to:

Cambrian Community Gym
Caplan Court
1 Grove Road,
Richmond
TW10 6SN

Tel: 020 8948 3351 Ext 1

Cambrian Community Gym

Exercise and Wellbeing Referral Form

Please <u>complete all sections of the form</u>, 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:			
		Postcode:	
		Tel. No:	
Postcode:		Fax. No:	
Contact Tel. No:		Email Address:	
Email Address:		**Referral No:**	

REGISTERED GP DETAILS			
Name:		Address:	
Practice:			
Tel. No:			
Fax. No:			
Email Address:		Postcode:	

REASON FOR REFERRAL:

MEDICAL INFORMATION: Please provide **<u>all relevant</u>** information about the patient's health status.

Resting HR:		**Systolic BP:**		**Diastolic BP:**		**BMI:**	

MEDICAL CONDITIONS: Please give details of **<u>all relevant current and past</u>** health problems**.**	
Details *i.e. Previous history of Chronic Fatigue*	**Dates** *Diagnosed 20th May 2000*
MEDICATION: Please provide a list of **<u>any medications being taken.</u>**	**PHYSICAL LIMITATIONS:**

	Please provide details **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 the form.
e.g. awaiting further investigations

AUTHORISATION I can confirm that the details given are a true reflection of the patient's medical history & medication, I refer this patient to the physical activity scheme under the terms & conditions set out in the protocol.	
Name of Referring Practitioner (PLEASE PRINT)	
Signature of Referring Practitioner	
Contact Telephone No.	
Date of Referral	

PATIENT CONSENT[i] The Exercise Referral Scheme has been fully explained to me. I am prepared to participate and I give 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 their Referring Practitioner in order to be re-referred.

Physical Activity Referral 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***.

Please send any completed forms directly to: **Cambrian Community Gym,** **Caplan Court,** **1 Grove Road,** **Richmond,** **TW10 6SN Tel: 020 8948 3351**	All information in this form will be treated in confidence and kept securely in accordance with The Cambrian Centre's Privacy Statement, prepared in compliance with the General Data Protection Regulation. The Privacy Statement is available at https://cambriancentre.org/privacy-statement/

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