PROGRESSIVE SPORTS AND SPINAL PHYSIOTHERAPY

Please fax or email completed referral form to **info@progressiverehab.com.au**
For enquiries, call **(02) 4721 7798**

HEAL HEALTHY EATING ACTIVITY & LIFESTYLE™

HEAL REFERRAL FORM for GPs & Health Professionals

Surname: _____ First name: _____

DOB: _____/_____/_____ Gender: M / F Aboriginal and/or Torres Strait Islander: Yes / No

Postcode: _____ Phone: _____ Health Care/ Concession Card: Yes / No

REFERRAL CRITERIA

- ☐ Type II Diabetes
- ☐ At high risk of Type II Diabetes
- ☐ BMI ≥ 30kg/m2
- ☐ 2 or more cardiovascular disease risk factors

REFERRAL INFORMATION

Referring provider: _____

Location of service: _____ Email: _____

Primary contact name: _____ Contact number: _____

Treatment aligns with GP Management Plan (MBS Item 721): Yes / No

Current team care arrangement (MBS Item 723): Yes / No

Recent Aboriginal and/or Torres Strait Islander Health Check (MBS Item 715): Yes / No

CONTRAINDICATIONS

ABSOLUTE: IF ALL ITEMS ARE NOT CHECKED YOUR PATIENT IS NOT SUITABLE FOR EXERCISE

- ☐ No recent significant change in resting ECG, recent MI, unstable angina or uncontrolled arrhythmia
- ☐ No symptomatic severe aortic stenosis, uncontrolled symptomatic heart failure, myocarditis or pericarditis
- ☐ No suspected or known dissecting aneurysm, acute pulmonary embolus or infarction, acute systemic infection

RELATIVE: THESE ITEMS ARE DISCRETIONARY IF EXERCISE BENEFITS OUTWEIGH RISKS

- ☐ No severe hypertension (SBP≥200mmHg, DBP≥110mmHg), left main coronary stenosis, moderate stenotic heart disease
- ☐ No high degree AV block, ventricular aneurysm, hypertrophic cardiomyopathy,tachydysrhythmia or bradydysrhythmia
- ☐ No electrolyte abnormalities, uncontrolled metabolic disease

Comments:

_____

GP & PATIENT CONSENT

- As the GP, I have discussed what the exercise program involves, the benefits and potential risks/discomforts
- The contraindications section and further investigations necessary have been completed
- I agree, in conclusion with the patient, that they are suitable for a low to moderate exercise assessment and exercise sessions
- As the patient, I have read and understand the 'Participating in the HEAL program' (below)

GP signature: _____ Date: ____/_____/_____

Patient/Parent/Guardian: _____ Date: ____/_____/_____

Participating in the HEAL Program

- Participation in the program is voluntary.
- Your personal information remains confidential and all data collected is stored in a secure location. Staff who have access to this data have signed confidentiality agreements. Collated & de-identified data (where all of your personal details have been removed) may be provided to the Commonwealth Department of Health & Ageing and may be used for the purposes of auditing, research, evaluation & quality assurance.
- I hereby agree to my record being provided to the HEAL facilitator to assist in my health management. I understand that I have the right to withdraw consent at any time, without penalty, by requesting that my personal information be deleted.
- This consent is subject to: 1) the information stored being kept secure & confidential; 2) any information required for an audit, research &/or planning being used on an anonymous basis.
- I also understand that if I have any question relating to the security of my personal information I can ask my doctor, my HEAL facilitator or the HEAL National coordinator 1300 179 765.