REFERRAL FORM

FAILURE TO COMPLETE ALL INFORMATION WILL DELAY REFERRAL

Ability Bow
PASSIONATE ABOUT PEOPLE

Shaded Fields are Optional

PREVIOUSLY KNOWN/NOT KNOWN

Date of Referral:

Database ID:

Patient Details	**Current GP**
First Name:	Initial:
Last Name:	Surname:
Address	Surgery:
	Address:
Local Authority:	
Date of Birth:	
Home Telephone No:	Tel No:
Mobile No:	Fax No:
Email:	**If Referrer is NOT GP, GP Consent must be obtained**
Gender: Male/Female:	**Sexuality:** Gay ☐ Heterosexual ☐ Lesbian ☐ Declined ☐
Ethnic Group: (please pick from attached form)	**Religion:** (please pick from attached form)

Next of Kin	Address:
Name	
Telephone No:	Relationship to Patient

Type of Referral:	**Referral From:**
Referred ☑	GP ☐ Other Professional ☐

Referring GP	**Consenting GP (if different to referrer please complete Consent Form)**	**Referring Other Professional:**
Initial:	Initial:	Initial:
Surname:	Surname:	Surname:
Surgery:	Surgery:	Service::
Address:	Address:	Address:
Telephone No:	Telephone No:	Telephone No:
Fax:	Fax:	Fax:

Main Reason for Attending (Please tick one only):

Anxiety/Stress	☐
Asthma	☐
Diabetes	☐
Hypertension	☐
Inactive/Sedentary	☐
Ischaemic Heart Disease	☐
Mental Health	☐
Other CHD Risk	☐
Osteoporosis	☐
Osteoarthritis	☐
Social Inclusion	☐
Weight Reduction	☐
Other (please state)	☐

Current Medication:

α Blockers	☐
ACE Inhibitors	☐
Anglo Tension Antagonists	☐
Anti-coagulants	☐
β Blockers	☐
Calcium Channel Blockers	☐
Dioxin/Amiodarone	☐
Diuretics	☐
Nitrates	☐
None	☐
Potassium Channel Activators	☐
Other (please state)	☐

Sensory Disability		**Special Equipment:**	
Cognitive	☐	Mobility Aid	☐
Hearing	☐	None	☐
Learning	☐	Walking Stick	☐
Speech	☐	Wheelchair	☐
Visual	☐		
None	☐	Other (please state)	☐

Main Health Condition (please tick one only):		**Secondary Health Condition:**	
Cerebral Palsy	☐	Cerebral Palsy	☐
CHD	☐	CHD	☐
Chronic Back	☐	Chronic Back	☐
COPD/Asthma	☐	COPD/Asthma	☐
CVA	☐	CVA	☐
Diabetes	☐	Diabetes	☐
Head Injury	☐	Head Injury	☐
Inactive	☐	Inactive	☐
Joint Problems	☐	Joint Problems	☐
Mental Illness	☐	Mental Illness	☐
MS	☐	MS	☐
Muscular Atrophy	☐	Muscular Atrophy	☐
Neurological Disease	☐	Neurological Disease	☐
Obesity	☐	Obesity	☐
Parkinson's	☐	Parkinson's	☐
Spinal Injury	☐	Spinal Injury	☐
Weight Loss	☐	Weight Loss	☐
Other (please state)	☐	Other (please state)	☐

History of Present Condition:

Signature of Referrer: ..... **Date:** .....

Office use only	
Date Referral Received:	Date Patient contacted:
Outcome of Referral:	
Waiting List ☐	Active Status ☐
Assessment Offered ☐	Active Status ☐
Inappropriate ☐	Inactive Status ☐
No Contact from Client ☐	Inactive Status ☐

Please return this form to:

Reception
Ability Bow Centre
St Paul's Church
St Stephen's Road, Bow E3 5JL.

Email: referrals@abilitybow.org
Telephone: 0208 980 7778
Fax : 0208 980 0344.

Registered Charity 1115595

ONLY TO BE USED IF CURRENT GP IS NOT THE REFERRER

FOR EXAMPLE WHEN REFERRED BY ANOTHER HEALTH PROFESSIONAL

Ability Bow

PASSIONATE ABOUT PEOPLE

Ability Bow
St. Paul's Church
St. Stephen's Road Bow
London E3 5JL
Telephone 020 8980 7778
Fax 020 8980 0344
Email: reception@abilitybow.co.uk
www.abilitybow.org

Dear Dr ____________________

Your patient ____________________ has been referred to Ability Bow gym

by: ____________________________________ to take part in supervised exercise sessions ;

they will be instructed by a qualified Level III Fitness Instructor.

For the safety of our clients it is the policy of ability Bow to obtain permission from the GP before the client commences their exercise program.

Would you please complete the section below and return it to Ability Bow via fax or email?

Thank you for your time.

Yours Sincerely

- ✂

I consider_________________________ to have medical conditions that exclude him/her from exercise.

I consider _________________________ to have NO medical conditions to exclude him/her from exercise.

Comments:

Client Name _________________________ Client Signature _________________________

GP's name: _________________________ GP's Signature _________________________

Date: ___________________

ETHNIC GROUP/RELIGION FORM

Ability Bow collects information about ethnic group and religion of service users. This information can help us to plan how to meet the needs of the community and help us provide a better service.

All the information you give us will be used and treated with the strictest confidence. Any planning information on general release will be anonymous with all names removed.

The level of care you are offered will not be affected by the completion of this form.

Please ask a member of staff if you have any queries.

Please tick only one Ethnic Group and one Religion:

ETHNIC GROUP	
WHITE	
British (English, Scottish, Welsh)	
Eastern European (including ex-Yugoslavia & USSR)	
Greek (including Greek Cypriot)	
Irish	
Jewish	
Other White European	
Orthodox Jewish	
Other White, Mixed White, White Unspecified	
Turkish (including Turkish Cypriot)	
MIXED	
White and Asian	
White and Black African	
White and Black Caribbean	
Other Mixed, Mixed Unspecified	
ASIAN	
Bangladeshi or British Bangladeshi	
Pakistani or British Pakistani	
Indian or British Indian	
Other Asian, British Asian, Asian Unspecified	
BLACK	
African (except Somali)	
Black British	
Caribbean	
Other Black, Black Unspecified	
Somali	
OTHER	
Arab or Middle East	
Chinese	
Kurdish	
Traveller	
Vietnamese	
Any Other Group	

RELIGION	
Atheist	
Baha'I	
Baptist	
Buddhist	
Church Of England	
Hindu	
Jain	
Jehovah's Witness	
Jewish	
Methodist	
Muslim	
Other Christian	
Orthodox Jewish	
Roman Catholic	
Seventh Day Adventist	
Shinto	
Sikh	
Zoroastrian/Pharsi	
Any Other Group	