

REFERRAL FORM

FAILURE TO COMPLETE ALL INFORMATION WILL DELAY REFERRAL



Shaded Fields are Optional

PREVIOUSLY KNOWN/NOT KNOWN

Date of Referral:

Database ID:

Patient Details First Name: Last Name: Address: Local Authority: Date of Birth: Home Telephone No: Mobile No: Email:		Current GP Initial: Surname: Surgery: Address: Tel No: Fax No: If Referrer is NOT GP, has GP Consent been obtained YES / NO	
Gender: Male/Female:		Sexuality: Gay <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Declined <input type="checkbox"/>	
Ethnic Group: (please pick from attached form)		Religion: (please pick from attached form)	
Next of Kin Name: Telephone No:		Address: Relationship to Patient	
Type of Referral: Referred <input checked="" type="checkbox"/>		Referral From: GP <input type="checkbox"/> Other Professional <input type="checkbox"/>	
Referring GP Initial: Surname: Surgery: Address: Telephone No: Fax:	Consenting GP (if different to referrer please complete Consent Form) Initial: Surname: Surgery: Address: Telephone No: Fax:	Referring Other Professional: Initial: Surname: Service: Address: Telephone No: Fax:	
Main Reason for Attending (Please tick one only): Anxiety/Stress <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Inactive/Sedentary <input type="checkbox"/> Ischaemic Heart Disease <input type="checkbox"/> Mental Health <input type="checkbox"/> Other CHD Risk <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Social Inclusion <input type="checkbox"/> Weight Reduction <input type="checkbox"/> Other (please state) <input type="checkbox"/>		Current Medication: α Blockers <input type="checkbox"/> ACE Inhibitors <input type="checkbox"/> Anglo Tension Antagonists <input type="checkbox"/> Anti-coagulants <input type="checkbox"/> β Blockers <input type="checkbox"/> Calcium Channel Blockers <input type="checkbox"/> Dioxin/Amiodarone <input type="checkbox"/> Diuretics <input type="checkbox"/> Nitrates <input type="checkbox"/> None <input type="checkbox"/> Potassium Channel Activators <input type="checkbox"/> Other (please state) <input type="checkbox"/>	

Sensory Disability Cognitive <input type="checkbox"/> Hearing <input type="checkbox"/> Learning <input type="checkbox"/> Speech <input type="checkbox"/> Visual <input type="checkbox"/> None <input type="checkbox"/>	Special Equipment: Mobility Aid <input type="checkbox"/> None <input type="checkbox"/> Walking Stick <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other (please state) <input type="checkbox"/>
Main Health Condition (please tick one only): Cerebral Palsy <input type="checkbox"/> CHD <input type="checkbox"/> Chronic Back <input type="checkbox"/> COPD/Asthma <input type="checkbox"/> CVA <input type="checkbox"/> Diabetes <input type="checkbox"/> Head Injury <input type="checkbox"/> Inactive <input type="checkbox"/> Joint Problems <input type="checkbox"/> Mental Illness <input type="checkbox"/> MS <input type="checkbox"/> Muscular Atrophy <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Obesity <input type="checkbox"/> Parkinson's <input type="checkbox"/> Spinal Injury <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other (please state) <input type="checkbox"/>	Secondary Health Condition: Cerebral Palsy <input type="checkbox"/> CHD <input type="checkbox"/> Chronic Back <input type="checkbox"/> COPD/Asthma <input type="checkbox"/> CVA <input type="checkbox"/> Diabetes <input type="checkbox"/> Head Injury <input type="checkbox"/> Inactive <input type="checkbox"/> Joint Problems <input type="checkbox"/> Mental Illness <input type="checkbox"/> MS <input type="checkbox"/> Muscular Atrophy <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Obesity <input type="checkbox"/> Parkinson's <input type="checkbox"/> Spinal Injury <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other (please state) <input type="checkbox"/>

History of Present Condition:

Signature of Referrer:

Date:

Office use only	
Date Referral Received:	Date Patient contacted:
Outcome of Referral: Waiting List <input type="checkbox"/> Assessment Offered <input type="checkbox"/> Inappropriate <input type="checkbox"/> No Contact from Client <input type="checkbox"/>	Active Status <input type="checkbox"/> Active Status <input type="checkbox"/> Inactive Status <input type="checkbox"/> Inactive Status <input type="checkbox"/>

Please return this form to:

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

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

Registered Charity 1115595



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
info@abilitybow.co.uk
www.abilitybow.co.uk

**ONLY TO BE USED IF CURRENT
GP IS NOT THE REFERRER**

**FOR EXAMPLE WHEN
REFERRED BY ANOTHER
HEALTH PROFESSIONAL**

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

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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	