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, has GP Consent been obtained YES / NO**
Gender: Male/Female:	**Sexuality:** Gay ☐ Lesbian ☐ Heterosexual ☐ 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:** (please complete Consent Form)
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):		**Current Medication:**	
Anxiety/Stress	☐	α Blockers	☐
Asthma	☐	ACE Inhibitors	☐
Diabetes	☐	Anglo Tension Antagonists	☐
Hypertension	☐	Anti-coagulants	☐
Inactive/Sedentary	☐	β Blockers	☐
Ischaemic Heart Disease	☐	Calcium Channel Blockers	☐
Mental Health	☐	Dioxin/Amiodarone	☐
Other CHD Risk	☐	Diuretics	☐
Osteoporosis	☐	Nitrates	☐
Osteoarthritis	☐	None	☐
Social Inclusion	☐	Potassium Channel Activators	☐
Weight Reduction	☐		
Other (please state)	☐	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 ☐ Assessment Offered ☐ Inappropriate ☐ No Contact from Client ☐	Active Status ☐ Active Status ☐ Inactive Status ☐ Inactive Status ☐

Please return a completed referral form by email to: referrals@abilitybow.org

Alternatively you may:

Fax: 0208 980 0344

or

Post to:
Ability Bow
St Paul's Church
St Stephen's Road, Bow E3 5JL

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

Telephone: 020 8980 7778
Fax: 020 8980 0344
Email: referrals@abilitybow.org
Website: www.abilitybow.org

Registered Charity 1115595

Ability Bow

PASSIONATE ABOUT PEOPLE

ONLY TO BE USED IF CURRENT GP IS NOT THE REFERRER

FOR EXAMPLE WHEN REFERRED BY ANOTHER HEALTH PROFESSIONAL

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

Telephone: 020 8980 7778
Fax: 020 8980 0344
Email: referrals@abilitybow.org
Website: 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: ____________________