Ability Bow Referral Form

Ability Bow
PASSIONATE ABOUT PEOPLE

FAILURE TO COMPLETE ALL INFORMATION WILL DELAY REFERRAL

Date of referral: _____ **Database ID *(Office use only):*** _____

***Patient Details*:**

First name _____ **Last name** _____

Address _____

Local Authority _____

Date of Birth _____

Home telephone No: _____ **Mobile No:** _____

Email address: _____

The following field is optional

Gender:

- ◯ Male
- ◯ Female
- ◯ Prefer not to say / Other

Sexuality:

- ◯ Gay
- ◯ Lesbian
- ◯ Heterosexual
- ◯ Prefer not to say / Other

Ethnic group: _____

Religion: _____

***Next of Kin*:**

Name: _____

Address: _____

Telephone No: _____ **Relationship to patient:** _____

***Current GP*:**

Initial: Surname:

Surgery

Address:

Telephone No: Fax:

Email:

Type of referral: ◯ GP ◯ Other Professional

***Referring GP*:**

As above listed current GP ◯ Yes
◯ No (Please fill in the below)

Initial: Surname:

Surgery

Address:

Telephone No: Fax:

Email:

Consenting GP (If different from referring GP, please complete GP consent form)

Initial: Surname:

Surgery

Address:

Telephone No: Fax:

Email:

Referring Other Professional (Please complete GP consent form)

First name: Surname:

Practice/ Service Address:

Telephone No: Fax:

Email:

Main reason for attending: (Please state one reason only)

Current medication:

- ☐ Alpha Blockers
- ☐ ACE Inhibitors
- ☐ Angio Tension Antagonists
- ☐ Anti-coagulants
- ☐ Beta Blockers
- ☐ Calcium Channel Blockers
- ☐ Dioxin/Amiodarone
- ☐ Diuretics
- ☐ Nitrates
- ☐ Potassium Channel Activators
- ☐ None
- ☐ Other (Please state)

Sensory disability:

- ☐ Cognitive
- ☐ Hearing
- ☐ Learning
- ☐ Speech
- ☐ Visual
- ☐ None

Special equipment:

- ☐ Mobility Aid
- ☐ Walking Stick
- ☐ Wheelchair
- ☐ None
- ☐ Other

Main health condition:

Secondary health condition:

- ☐ Cerebral Palsy
- ☐ CHD
- ☐ Chronic Back
- ☐ COPD/Asthma
- ☐ CVA
- ☐ Diabetes
- ☐ Head Injury
- ☐ Joint Problems
- ☐ Mental Illness
- ☐ MS
- ☐ Muscular Atrophy
- ☐ Neurological Disease
- ☐ Obesity
- ☐ Parkinson's Disease
- ☐ Spinal Injury
- ☐ Inactive
- ☐ Other (please State)

History of present condition:

Signature of referrer: **Date:**

Please return a completed referral form and send to:

Email: reception@abilitybow.org

Alternatively you may post to:

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

Tel: 0208 980 7778

Website: www.abilitybow.org

Ability Bow is a registered charity: Number***: 1115595***

Office use only:

Date referral received: ***Date patient contacted***

Outcome of Referral:
- ☐ Waiting list
- ☐ Assessment offered
- ☐ Inappropriate
- ☐ No contact from patient

Status:
- ◯ Active
- ◯ Inactive

Ability Bow

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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 upon which 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 their GP before the client commences their exercise program.

Kindly please complete the section below and return to Ability Bow via email or fax.

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: _____