

MEDICAL REPORT AND REFERRAL FORM

(please print all details)

- Surname: _____ ● Today's Date: ____/____/____
● Given Name: _____ ● Date of Birth: ____/____/____
● Contact Phone: _____ ● Gender: Male Female
● Marital Status: _____

● PERSON TO BE NOTIFIED IN CASE OF EMERGENCY ●

- Surname: _____ ● Given Name: _____
● Contact Phone: _____ ● Relationship: _____

● MEDICAL HISTORY – Client or Doctor to complete ●

- Have you ever required medical attention for any of the following (please tick or write in space provided)

		Year of onset (approx)		Year of onset (approx)
Diabetes	<input type="checkbox"/>	_____	Respiratory disease	<input type="checkbox"/> _____
Parkinson's disease	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/> _____
High blood pressure	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/> _____
Angina (chest pain)	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/> _____
Cardiac Rhythm Disturbance	<input type="checkbox"/>	Type: _____		
Heart Failure	<input type="checkbox"/>	EF (if known): _____		
Heart Attack	<input type="checkbox"/>	Site/s: _____		
Stroke	<input type="checkbox"/>	Residual effect/s: _____		
Arthritis	<input type="checkbox"/>	Site/s: _____		
Cancer	<input type="checkbox"/>	Type: _____		
Joint replacement	<input type="checkbox"/>	Site/s: _____		
Cognitive disorder	<input type="checkbox"/>	Type: _____		
Uncorrected visual problem	<input type="checkbox"/>	Type: _____		
Mental health condition	<input type="checkbox"/>	Describe: _____		
Chronic pain (history)	<input type="checkbox"/>	Severity/frequency: _____		

- Other Medical History (not outlined above) _____

- Do you currently have a medical condition that might limit your physical performance? No Yes
● Have you experienced any notable changes in your health in the past month (for example: dizziness, falls, increased pain, etc.)? No Yes

● CLINICAL ASSESSMENT – Doctor to complete ●

Pulse: Rate _____ Rhythm _____
Blood Pressure: Sitting _____ Standing _____
Auscultation: Breath sounds _____
Heart sounds _____
Murmurs _____

● Medication					
Name	Dosage	Frequency	Name	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

- I consider my client can safely participate in a **progressive**, physical activity program? No Yes
● I consider a progressive physical activity program is necessary to aid in the treatment of: _____

Doctor's Signature: _____ Date: _____

Name: _____ Phone: _____

Address: _____

Service Provider No: _____



Centre for Physical Activity in Ageing

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Dear Doctor

Your client has expressed an interest in one of the physical activity programs conducted by the Centre for Physical Activity in Ageing (CPAA), Hampstead Rehabilitation Centre. The CPAA is a unit of the Department of Geriatric and Rehabilitation Medicine, Royal Adelaide Hospital.

The aim of our programs are to a) introduce mature age persons individuals to a variety of physical activities, and b) improve physical fitness and general well being, through a structured program of physical activity.

Different types of programs are available and include:

- **GENERAL EXERCISE** - includes walking, stretching and strengthening and other aerobic activities. This program encompasses *slow* and *active pace* classes;
- **CIRCUIT EXERCISE** - includes the use of specialised training equipment including - exercise bikes, hydraulic resistance machines, treadmills and other resistance apparatus. All clients must participate in an introductory program before proceeding onto either a *slow*, *moderate* or *active pace* class;
- **WATER EXERCISE** - includes a range of stretching, strengthening and aerobic exercises conducted in an indoor, salt-chlorinated, hydrotherapy pool heated to 33.5⁰ C. This program encompasses *slow*, *moderate* and *active pace* classes;
- **SWIM FITNESS** - includes specific learn to swim and lap swimming programs;
- **CHRONIC DISEASE MANAGEMENT [Stroke Fitness]** - includes the use of specialised training equipment including - exercise bikes, hydraulic resistance machines, treadmills and other resistance apparatus and is aimed at clients with some **disability** or **physical restriction** arising from a cerebrovascular accident or related problem. Some classes are structured so as to permit participants to work on individualised programs within a group setting. The program aims to improve physical function and maintain previously made rehabilitation gains);
- **SECONDARY PREVENTION MANAGEMENT [Cardiac Rehabilitation]** (includes the use of specialised training equipment including - exercise bikes, hydraulic resistance machines, treadmills and other resistance apparatus) and is aimed at cardiac clients (at least 12 weeks post cardiac event) and those requiring modification of cardiovascular risk. Clients with diabetes, stress, hypertension, hypercholesterolaemia, obesity etc. are also encouraged to attend this class.

Programs allow clients to work at their own pace and are designed specifically for the older person.

Each program is directly supervised by accredited and experienced fitness instructors and/or exercise physiologists.

We have informed intending participants of our **mandatory requirement** for them to complete the attached form and contact their usual medical adviser prior to commencing any program of physical activity.

We would appreciate if you could complete the '**medical report and referral form**' notifying us of any restriction on the part of your client.

An Exercise Physiologist or Registered Nurse to assist in the selection of appropriate group placement offers a counselling session (at no charge) to all clients following referral.

Yours Sincerely

Dr Phil Hamdorf

PhD MAEES AEP FASMF

Chief Exercise Physiologist and
Head, Centre for Physical Activity in Ageing