

General Practice Details

Contact: Dr/Practice Nurse	
Address:	
Phone Number:	Fax Number:
Email:	

Patient Details

Name:			
Address:			
Preferred Phone Number:	(hm):	(wk):	(mb):
Age:	Gender: (please tick)	<input type="checkbox"/> Female	<input type="checkbox"/> Male
When is the best time and day for the Get Healthy Information and Coaching Service to call? (please tick)			
<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday
<input type="checkbox"/> Friday	<input type="checkbox"/> am	<input type="checkbox"/> pm	

Primary issue for referral:

<input type="checkbox"/> Healthy eating	<input type="checkbox"/> Physical activity	<input type="checkbox"/> Weight Management
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Health considerations:

Have you been in hospital in the last 6 months for serious illness or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Have you fully recovered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had an injury or illness related to the heart, lungs, or brain within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Have you fully recovered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been diagnosed with or are you currently being treated for:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Angina / Ischaemic Heart Disease	<input type="checkbox"/> Unstable Asthma
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mild Stroke	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Neurological disorder (eg: Parkinson's Disease)		
Do you have a pacemaker or similar?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any physical conditions or impairments that limit how you are able to be physically active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any special dietary requirements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently being treated for a mental illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Is it currently well managed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any other reasons why your doctor or practice nurse thinks you should not increase physical activity levels or change your current eating habits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you over the age of 80 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(If female) Are you currently pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Waist circumference (current):	cm	Weight (current):	kg	Height:	cm
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Patient Consent and Signature:

I consent to this information being sent to the Get Healthy Information and Coaching Service, and consent for the Service staff to call me at a time that has been suggested on this form.

I understand that the General Practice named above will receive written feedback of my contact with the Service.

Signature: _____ Date: _____

GP/Practice Nurse Signature:

I am monitoring any medical conditions that are detailed above.

Signature: _____

Date: _____