

General Practice Details

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|----------------------------|-------------|
| 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 |
|---|--|--|

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 |
|--------------------------------|----|-------------------|----|---------|----|

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.

GP/Practice Nurse Signature:

- I am monitoring any medical conditions that are detailed above.

Signature: _____

Signature: _____ Date: _____

Date: _____

