



Stroud District Respiratory Exercise Class Referral Form

Assessment Date:

Patient Name:

Assessed By:

Patient Address:	Next of Kin details:
Telephone Number:	Telephone Number:
Age:	
GP:	
Telephone Number:	

Diagnosis:	Other Relevant Medical Conditions:
Respiratory Medications:	Oxygen Prescription details:
Attended: Pulmonary Rehabilitation / Early Pulmonary Rehabilitation (delete as appropriate)	

SpO2:	HR (resting):	MRC grade:
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Additional Information:



Patient Informed Consent:

The Health Lifestyle Scheme is a partnership between Stroud District Council, Gloucestershire County Council, Gloucestershire Clinical Commissioning Group, Gloucestershire Care Services, Gloucestershire Hospitals NHS Foundation Trust, Stratford Park Leisure Centre, The Pulse, Fifth Dimension, and Richmond Village, which is intended to provide initiatives that promote and aid a healthy lifestyles.

The Healthy Lifestyle Scheme will process your medical details for the following purposes:-

- To enable us to assess your medical fitness and suitability for the Healthy Lifestyle Scheme initiative you have been referred to;
- To enable us to respond to any medical emergencies which arise during your involvement with the Health Lifestyle Scheme. We may pass this information to health professionals when dealing with any medical emergency;
- To enable the relevant Healthy Lifestyles Class Instructor to deliver an exercise session suitable for your medial conditions. This means that we will share relevant medical information about you that you have provided to us, with the Healthy Lifestyles Class Instructor who may be based at either Stratford Park Leisure Centre, The Pulse, Fifth Dimension and Richmond Village.

By ticking each box I consent to my sensitive personal details being processed for each purpose listed. You have the right to withdraw your consent at any time. Further information about your rights and how Stroud District Council processes your Information can be found on our [Privacy Policy](#).

I understand that I am responsible for monitoring my own responses to exercise and will inform the instructor of any changes in my condition that may impact on my ability to participate

Signed Date

Referrer Signature:

I am satisfied that there are no contraindications to exercise and have shared all details that I consider relevant to the patient's ability to exercise.

Signature:

Date:

For more information, please contact Community Health & Wellbeing on 01453 754508 for more information.

Email: - hwb@stroud.gov.uk

Website: - www.stroud.gov.uk