'Promoting the Health and Wellbeing of our Communities'

Stroud District

Cancer Rehab Exercise Class Referral Form

Patient Full Name: Patient Address: Date of Birth Age:	Telephone Number: Mobile Number: Email Address:
GP Surgery Name: Telephone Number:	

Cancer Site: Date and type of surgery: Lymph node procedure:	Treatments and dates: ☐ Radiotherapy ☐ Chemotherapy ☐ Others
Musculoskeletal problems prior to surgery:	☐ Lymphodema Site: ☐ Seroma Site:
Other medical problems/surgery:	
Current prescribed Medications	Current " over the counter" medications

Reason for Referral (e.g. reduced range of movement, tight scar etc)		
Referred by	Job Title	☐ GP ☐ Hospital Oncology/surgical specialist staff ☐ Other
Signature:	Telephone Number:	Date of Referral:

Patient Informed Consent:

I consent to participating in a structured exercise programme of low to moderate intensity, the nature and purpose of which has been explained by my GP/referring Health Professional. I consent to the release of relevant medical information about myself to a Qualified Exercise Referral Instructor. Information obtained will be treated as confidential, although it may be used anonymously for statistical or research purposes.

Signature:

Print Name:

Date:

Referrer Signature:

I recommend the above patient to participate in an exercise programme of moderate intensity. I confirm that I have assessed this patient and to my knowledge there is no medical reason why he/she should not participate in a recommended exercise programme. I confirm that I have discussed the scheme with the patient.

Signature:

Date:

For more information, please contact Sports & Health Development on 01453 754508 for more information.

Email: - GP.Referral@stroud.gcsx.gov.uk **Website: - www.stroud.gov.uk**