

# ACTIVITY ON REFERRAL (AOR) FORM

## Patient Information *(Please print clearly)*

Name..... Gender: Male  Female

Address..... Date of Birth: ...../...../.....

..... Tel No: .....

Post Code..... Date of referral: ...../...../.....

## Referral Information *(Please tick all that applies)*

Overweight/Obesity BMI > 30 or > 28 with co-morbidities	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Diabetes (Type I/Type II) <i>please circle</i>	<input type="checkbox"/>	COPD/Pulmonary ( <i>lung related</i> )	<input type="checkbox"/>
Q <sup>®</sup> Risk Score > 10%	<input type="checkbox"/>	Neurological (Parkinson's/MS)	<input type="checkbox"/>
Controlled hypertension (< 160/100 mmhg)	<input type="checkbox"/>	Back pain (not acute)	<input type="checkbox"/>
Impaired Strength or Mobility	<input type="checkbox"/>	Stable Angina (Controlled & stable for 6 months)	<input type="checkbox"/>
Smoker attempting to quit	<input type="checkbox"/>	Mild Depression/Anxiety/Stress	<input type="checkbox"/>
Pre-diabetes: fasting plasma glucose level of 5.5–6.9 mmol/l or an HbA1c level of 42–47 mmol/mol (6.0–6.4%).	<input type="checkbox"/>		<input type="checkbox"/>

<p><b>Current Medication</b> Please check for contraindications for physical activity</p>	<p><b>Additional Information</b> Any relevant medical conditions? (eg: mobility or cardiac problems etc) or any specific activities/exercise that would be inappropriate for this patient.</p>
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## Referrers Information

Name of Health Professional: ..... Signature: .....

Medical Practice: ..... Tel Number: .....

## Patient Informed Consent

The Activity on Referral (AoR) Scheme has been fully explained to me. I would like to participate in the scheme to increase my physical activity levels. I therefore give my consent for my personal information and the relevant clinical information about my health to be passed to the AoR Qualified Exercise Professional at the AoR Accredited Leisure Facility of my choice.

The information provided on this form will only be used as part of the AoR Scheme to ensure that the scheme is delivered within guidelines of the County Standard Protocol. All personal data will be stored securely.

Patient's Signature: ..... Date: ...../...../.....

Please print 2 copies of the referral form.

**Copy 1:** Give to the patient to take to the AOR facility.  
(NB: the patient is required to give this to exercise professional on initial visit and consultation)  
**Copy 2:** To be placed on the patients file.