Heart Foundation Heartmoves

Heart Foundation

PRE-EXERCISE ASSESSMENT AND REFERRAL FORM

SECTION 1

Licensee:	Leader:		Venue:	
Participant name:	Email:		Phone:	
Address:	State:	P/code:	Gender: M / F	DOB:
Currently Employed: ☐ Yes ☐ No	Aboriginal or Torres Strait Islander: ☐ Yes ☐ No		Private Health Insurance: ☐ Yes ☐ No	
HCI funded participant: ☐ Yes ☐ No	Emergency contact name:			Phone:
Doctor's name:	Phone:		Fax:	
Address:		State:	Postcode:	

SECTION 2

- I understand that the Heartmoves leader cannot give me medical advice.
- I will tell the leader immediately if I feel any symptoms OR if my health status should change from that below.
- I will consult my GP if I wish to try to exercise at a different intensity from Heartmoves.
- I agree to follow the directions of my Heartmoves Leader in my Heartmoves exercise program & will exercise at my own pace.
- I authorise the Heartmoves leader and my GP to communicate about my progress in Heartmoves & understand that they are bound by the privacy act and will only use information pertinent to my exercise program and medical condition as it relates to exercise.
- I understand that a copy of this form and information on my attendance and evaluation goes to the Heartmoves Management Team (at the National Heart Foundation of Australia) for monitoring, and they are bound by the privacy act to use this information for statistical purposes only. For Privacy Policy see www.heartfoundation.org.au.

☐ Please tick if you would like to receive information from the National Heart Foundation of Australia

When you have read and understood the above statements it is important that you sign and date here: _____ / /

Heartmoves Participant — Today's Date

SECTION 3

Please tick the appropriate box if you have, ever had, or are on medication for:

Yes	No		Yes	No
☐	☐	Heart problems – heart attack, angina, palpitations, bypass, pacemaker, valves, angioplasty, etc	☐	☐
☐	☐	Discomfort in the chest at rest or exertion	☐	☐
☐	☐	Epilepsy	☐	☐
☐	☐	Asthma, emphysema, bronchitis – other lung problems	☐	☐
☐	☐	Discomfort in the legs at rest or exertion	☐	☐
☐	☐	Arthritis or major injuries in any joints	☐	☐
☐	☐	Severe vein disorders in the legs or feet, or ulcers	☐	☐
☐	☐	Liver condition	☐	☐
☐	☐	Kidney condition	☐	☐
☐	☐	Rheumatic Fever	☐	☐
☐	☐	Other (please describe):	☐	☐

	Yes	No
Diabetes	☐	☐
High cholesterol	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Hernia	☐	☐
Osteoporosis	☐	☐
Swollen feet/ankles	☐	☐
Glandular Fever	☐	☐
Eating Disorder	☐	☐
Dizziness/fainting	☐	☐
Cancer	☐	☐
Multiple Sclerosis	☐	☐

If you ticked "Yes" to any of these conditions, it is advised that medical clearance be obtained from your doctor prior to exercising (take this form with you)

OR If you already have a recommendation from your GP to exercise please sign here: _____ / /

Heartmoves Participant — Today's Date

SECTION 4

To be completed by Exercise, Health and/or Medical Professional

This form was initiated by *(please tick)*: ☐ Heartmoves Leader ☐ GP ☐ Cardiac Rehabilitation ☐ Diabetes Educator ☐ Dietitian ☐ Physiotherapist ☐ Exercise Physiologist ☐ Community Health ☐ Practice Nurse ☐ Specialist ☐ Other: _____

Heartmoves goal for this client: _____

Feedback requested by health professional: ☐ Only in the event of problems ☐ 3 months ☐ 6 months ☐ 12 months

Feedback to be sent to: **Name:** _____ **Phone:** _____ **Fax:** _____

☐ This client has a **Care Plan** (summary attached) For eligibility guidelines: www.heartfoundation.org.au/heartmoves

This client should exercise at: ☐ Low intensity (or seated) ☐ Low-Moderate intensity ☐ Moderate intensity

This client must stop exercising if: _____

Doctor's Signature for Medical Clearance: **Today's Date:** / /

WHITE: **Heartmoves leader's** copy – for client file

PINK: Heartmoves leader sends this copy to: **Heartmoves Data Management Officer**, PO Box 2222, Strawberry Hills, NSW 2012

GREEN: **GP copy** for patient file

YELLOW: **Allied Health Professional copy** for patient file