

DOCTOR REFERRAL LETTER



Dear **Strength for Life Provider**,

I am recommending my patient/client undertake a monitored Strength for Life strength training program that incorporates a progressive resistance format.

TYPES OF PROVIDERS:

Tier One - Exercise physiologists and physiotherapists

Tier Two - Fitness professionals who have completed the SFL™ advanced training course.

ELIGIBILITY FOR REFERRAL

Anyone over 50 years of age or those over 40 years of age with a disability.

INSTRUCTIONS FOR REFERRAL

1. Those who present with three or less low level risk factors please refer to a Tier Two Provider.
2. Those with chronic conditions, injury rehabilitation needs or four or more risk factors refer to Tier One Provider.

PARTICIPANT DETAILS

Title (Miss, Ms, Mrs, Mr): _____ Name: _____

Address: _____

Suburb: _____ Postcode: _____

Date of Birth: _____ Age: _____ Gender: Male Female

BLOOD PRESSURE

Blood Pressure: _____ Date Tested: _____

MEDICAL CONDITIONS

Please tick the appropriate box(es).

| | | | |
|--|--|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Brain/Spinal Injury | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Neurological disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Muscular pain | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Fall/Poor Balance | <input type="checkbox"/> Cancer | <input type="checkbox"/> Broken Bones |

HEALTH HISTORY/CURRENT MEDICATIONS

Please attach a summary print out of medical history and current medications. Please elaborate in the notes if required.

NOTES

I Doctor _____ refer _____

To undertake the Strength for Life™ program.

Please consider the following when prescribing a training program:

1. _____
2. _____
3. _____
4. _____
5. _____

Please tick one of the following regarding your patient's progress:

- Yes, I do wish to be kept informed of the client/patient's progress
- No, I don't wish to be kept informed of the client/patient's progress

Signature: _____

Date: _____

REFERRAL TYPE (Please tick one box):

- Tier One - classes provided by Exercise Physiologists and Physiotherapists
- Tier Two - classes provided by Fitness Professionals who have completed the Strength for Life™ advanced training course.
- Working Seniors Tier - for Seniors who need to attend outside standard working hours. Patient must be capable of participating in Tier Two environments without supervision.

REFERRING ORGANISATION OR CENTRE DETAILS

| |
|------------------------------|
| Name of Medical Centre: |
| Address of referring Centre: |
| Name of person referring: |
| Contact numbers: |
| Fax number: |
| Email address: |



FOR CLARIFICATION CONTACT

COTA (WA)

PH : (08) 9472 0104

sfl@cotawa.org.au

Please do NOT fax or email this form to COTA
WA – Patient to take to nearest
Strength for Life provider