

## ST GEORGE ALLIED HEALTH EDUCATION & TRAINING HUB GP REFERRAL FORM

Group education and exercise programs focusing on chronic disease prevention and management; and healthy ageing and falls prevention. Programs are delivered at no cost by an interprofessional health team.


| PATIENT INFORMATION |  | REFERRER INFORMATION |  |
|---------------------|--|----------------------|--|
| Full Name           |  | Referring Doctor     |  |
| Date of Birth       |  | Medical Clinic       |  |
| Address             |  |                      |  |
| Phone Number        |  |                      |  |
| Email               |  | Clinic Phone Number  |  |

Please select relevant inclusion criteria below:

| HEALTHY LIFESTYLES  | STRENGTH & BALANCE   | EXCLUSION CRITERIA (both programs)  |
|---|--|---|
| Over the age of 18 years with <b>one or more</b> of the following:<br>AUSDRISK score 6+ (intermediate/high risk)<br>Not meeting Australian Physical Activity Guidelines<br>Current/past high blood sugar inc. gestational diabetes<br>Current/past high blood pressure, inc. taking blood pressure medication<br>Waist measurement ≥94cm (male) or ≥80cm (female) | Over the age of 50 years with <b>one or more</b> of the following:<br>A recent fall – in the last 12 months<br>Fearful of falling<br>Desire to improve balance | <b>Any</b> of the following:<br><ul style="list-style-type: none"> <li>Blood pressure &gt;180/110mmHg</li> <li>Acute change in function</li> <li>Symptom acuity impacting on capacity to engage in program</li> <li>Significant cognitive impairment</li> <li>Unable to participate in a group environment</li> <li>Unable to safely independently mobilise (with/without mobility aids)</li> <li>Any condition that may require 1:1 supervision during exercise/sessions</li> <li>Pregnancy</li> </ul> |
| Patient information relevant to their capacity to participate in a <u>group exercise and education program</u> :<br>e.g. mental/physical conditions or issues under investigation   |  |   |
|   |  |   |
| This patient is able to engage in exercise:   | With restrictions (please specify):<br>Without restrictions  |   |

Please attach the following:  
**PATIENT HEALTH SUMMARY**  
**MEDICATIONS LIST**  
**RECENT PATHOLOGY**

If your practice uses Medical Objects please send referral documents to:  
**SQRH St George Allied Health Education and Training Hub**  
**ID: SS 448 70 00 7P**



\* Referrals will **not** be considered unless all information is included \*

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A COLLABORATION BETWEEN: