



DOCTOR REFERRAL LETTER



Dear Strength for Life™ Co-ordinator,

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 _____ authorise _____

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

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