

Referral Form



PASSIONATE ABOUT PEOPLE

Patient name: Patient address: Telephone no: Mobile no: Date of birth:	GP name: GP address: GP tel no: Fax no: GP Consent given Written: yes/no Verbal: yes/no
Emergency contact no:	Most convenient Ability Centre: Bow: <input type="checkbox"/>
Referral Reasons: Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Weight reduction <input type="checkbox"/> Other CHD risk <input type="checkbox"/> Anxiety/Stress <input type="checkbox"/> Asthma <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Inactive/sedentary <input type="checkbox"/> Ischaemic heart disease <input type="checkbox"/> Mental health <input type="checkbox"/> Social inclusion <input type="checkbox"/> Other relevant information: (continue on back of form if necessary)	
History of present condition: 	
Current medication: Potassium channel activators <input type="checkbox"/> β -blockers <input type="checkbox"/> Digoxin/amiodarone <input type="checkbox"/> ACE inhibitors <input type="checkbox"/> Calcium channel blockers <input type="checkbox"/> α -blockers <input type="checkbox"/> Anti-coagulants <input type="checkbox"/> Other: Angiotensin antagonists <input type="checkbox"/> Diuretics <input type="checkbox"/> Nitrates <input type="checkbox"/>	
Need for specific equipment: Mobility aid <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walking stick <input type="checkbox"/> Other <input type="checkbox"/>	
Name of referrer if other than GP: Contact address: Contact number:	Designation: Date of referral: Fax:

Signature of referrer:

Date:

Office use only		Ability Bow key person:	
Date referral received:		Date patient contacted:	
Date start of exercise:		Date completed:	

**Please return this form to: Victoria Kent or Joanne Roche: Ability
Centre Bow, St Paul's Church, St Stephen's Road, Bow E3 5JL.
E: referrals@abilitybow.co.uk T: 0208 980 7778 F: 0208 980 0344.**

Registered Charity 1115595