MEDICAL REFERRAL FORM - TIER 1

Dear Strength for life Coordinator,

I am recommending this patient undertake a supervised Strength for life Tier 1 program that is individualised and progressive. I understand that this program will be monitored by an exercise physiologist or physiotherapist.

CLIENT DETAILS:

Name: _____ Date of Birth: _____

Address: _____ Post Code: _____

1. Does the client have any of the following health conditions?

❒ Respiratory Problems	❒ Diabetes	❒ Back Problems
❒ High Blood Pressure	❒ Joint conditions	❒ Joint Replacement
❒ Heart Conditions	❒ Neurological conditions	❒ Cognitive issues
❒ Osteoporosis	❒ Chronic pain	❒ Falls History

Details of conditions/current medication:

_____

_____

_____

2. Recommendations:

_____

_____

_____

3. I would like to be kept informed of my client's progress Yes No

REFERRAL DETAILS:

Medical Practitioner Name: _____

Organisation / Facility: _____

Address: _____

Phone Number: _____ Email: _____

Providers Signature: _____ Date: _____