Strength for Life

COTA South Australia

Enrolment Form

SFL Facility Name: .....

Name ..... **Date of Birth** .....

Address ..... **Post Code** .....

Phone ..... **Gender** .....

Email .....

Cultural Identity ..... **Language spoken at home** .....

Do you identify as Aboriginal or Torres Strait Islander ☐ **Yes** ☐ **No**

Referral Source:

☐ Medical Practice ☐ Rehabilitation Services ☐ Health Clinic

☐ Physiotherapist ☐ Falls Prevention Service ☐ Healthy Lifestyle Program

If self-referred, where did you hear about Strength for Life Program?

☐ Local Newspaper ☐ Friend/Family ☐ Presentation from COTA SA

☐ COTA SA Publication ☐ Social Media ☐ Website

What was your reason to start Strength Training?

☐ Medical recommendation ☐ Preventative action ☐ Stay fit and healthy

☐ Social interaction ☐ Weight management ☐ Chronic disease management

☐ To improve strength ☐ To help after injury ☐ Improve Balance

I agree that the information I share will inform Strength for Life reports and recommendations for funding bodies. My personal information is de-identified, remains confidential and is stored securely in a password protected database. My email address will be used to notify me of any COTA SA opportunities or events.

Signature of Participant: ..... **Date:** .....

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Pre-exercise Screening Form

This form is used to determine if there is any further information that will be required from your doctor or treating health professional before commencing the Strength for Life (SFL) program.

Client details

Name:..... **Date of Birth**.....

Address..... **Post Code**.....

Phone Number..... **Mobile**.....

GP..... **Phone Number**.....

Emergency Contact..... **Phone Number**.....

**** It is recommended that all participants intending to participate in SFL sessions visit their Doctor beforehand, so that their ongoing health can be managed appropriately.****

Do you have a heart condition? e.g. Angina, cardiovascular disease	☐ Yes	☐ No
Do you have a neurological condition? e.g. stroke, parkinsons, MS, MND	☐ Yes	☐ No
Do you have high or low blood pressure which is not managed?	☐ Yes	☐ No
Do you have diabetes which is unstable?	☐ Yes	☐ No
Do you have a respiratory condition? e.g. asthma, emphysema, COPD	☐ Yes	☐ No
Are you over age 65 and been completely inactive for the last 2 years?	☐ Yes	☐ No
Have you ever had cancer requiring chemotherapy or radiotherapy?	☐ Yes	☐ No
Have you ever been diagnosed with osteoporosis? **Bone Density report required**	☐ Yes	☐ No

***If you answered YES to one or more of the above questions you will need to consult your Doctor in person for a referral to Strength for Life** (Medical referral form)**

Do you or have you ever suffered from back problems requiring treatment?	☐ Yes	☐No
Do you have knee or hip problems that require ongoing attention?	☐ Yes	☐No
Do you have arthritis which requires health professional assistance?	☐ Yes	☐No

****If you answered YES to one or more of the questions above, and are presently consulting your allied health professional (physio or exercise physiologist), you may be referred to SFL using the Allied Health Referral form.**
These referral forms are available from the website, SFL provider or your medical or allied health professional

If you answered No to all questions above, you may book in for an assessment with the SFL instructor. **If it is the Partner Centre's policy that all clients require a referral form from their treating health professional, this supercedes the previous statement.**

Please note that it is the client's responsibility to accurately answer the questions above. It is also the responsibility of the client to tell the Strength for life Instructor of any changes in health status that differs from those above. It is recommended you inform your treating health professionals of your involvement in SFL.

Client Signature:..... **Date:**.....

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Medical Referral Form - Tier 1

Dear Strength for Life coordinator,

I am recommending my patient undertake a supervised Strength for Life Tier 1 program that is individualised and progressive. I understand that this program will involve an exercise physiologist or physiotherapist with SFL accreditation.

Client details

Name ..... **Date of Birth** .....

Address ..... **Post Code** .....

1. The client has presented with low level of health risk factors or managed conditions:
Details of conditions/current medication:

.....

.....

.....

2. Recommendations/goals/restrictions:

.....

.....

3. I would like to be kept informed of my clients progress ☐ **Yes** ☐ **No**

Referral details

Medical Practitioner Name .....

Organisation/Facility .....

Address .....

Phone Number:..... **Email:** .....

Signature:..... **Date:**.....

Strength for Life

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Allied Health Referral Form

Client details

Name ..... **Date of Birth** .....

Address ..... **Post Code** .....

Contact Number ..... **Alternative Contact number** .....

1. Regular Doctor's Name: ..... **Doctor's Phone:** .....

2. Goals for participating in this program are:

- ☐ Improve Balance
- ☐ Increase Fitness
- ☐ Increase Flexibility
- ☐ Increase Social Contact
- ☐ Manage Health Problems
- ☐ Increase Strength

3. Does the client have any of the following health conditions:

- ☐ Asthma
- ☐ Neurological Conditions
- ☐ Back Problems
- ☐ High Blood Pressure
- ☐ Joint conditions
- ☐ Joint Replacement
- ☐ Cardiovascular Conditions
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Chronic pain
- ☐ Falls History

4. Current medication? If yes, please list those that may affect client whilst exercising:

.....

Referral details

Allied Health Practitioners Name: .....

Organisation/Facility: ..... Phone: .....

I am recommending my client participate in Strength for Life session: ☐ **Yes** ☐ **No**

Reason for referral: .....

Contraindications: .....

Recommended strength training exercises/stretches: .....

.....

.....

I understand that prior to commencing, my client will be prescribed strength training program, based on the health information and exercise therapy assessment provided.

Signature of Provider: ..... **Date:** .....