**Active Herts – Referral Form**Active Herts is a service that provides one to one support for inactive, CVD risk and mental health patients/clients. Following referral into the service, patients will be offered FREE face to face consultations delivered by trained physical activity practitioners who will use behaviour change and motivational interviewing to support patients to become more active.

**Essential inclusion criteria *(all referrals must meet these)***

* Adults (aged 16 years and over)
* Resident of Hertfordshire
* Inactive (<30 mins Physical Activity per week)

**Additional inclusion criteria (referrals may also have)**

* Diabetes Mellitus
* Hypertension
* Obesity (BMI >30, or BMI >28 if one or more co-morbidities)
* Smoker
* High Cholesterol
* History of heart disease
* Family history of heart disease
* Mild to moderate mental health condition

***IMPORTANT: Please answer this question. Referrals will only be eligible for the service if they score 0 days or 1 day.***

|  |  |
| --- | --- |
| In the past week, on how many days has the patient done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate? This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that may be part of the patient’s job. | |
| **Eligible score** | **Ineligible score** |
| ☐0 days ☐ 1 days | ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days |

|  |  |
| --- | --- |
| **Referral Date:** Click here to enter a date. | |
| **Patient Name:** | **Date of Birth:** |
| **Address:** | **Gender:** Choose an item. |
| **County:** Hertfordshire | **Ethnicity:** Choose an item. |
| **Postcode:** | **Telephone:**  **NOTE:** All referral will be followed up by telephone. |
|  |
| **Reason for referral:** For example, to increase level of exercise, to help self-manage a pre-existing medical conditions. | |
| **Medical Conditions:** Please provide brief details of **current** medical conditions that may affect the patient’s ability to exercise. | |
| **Contraindications to exercise:** Does the patient have any of the following contraindications? | |
| ☐Established ischaemic heart disease  ☐Hypertension Systolic: >180mmHg or Diastolic: >100mmHg  ☐Uncontrolled Type 1 diabetes  ☐Severe or poorly controlled asthma  ☐Chronic pulmonary disease  ☐Cerebro-vascular disease | ☐Peripheral vascular disease  ☐Unstable or severe mental health state  ☐Resting Heart Rate > 100 BPM  ☐Febrile Illness  ☐Heart Failure  ☐Aortic Valve Stenosis |

|  |  |
| --- | --- |
| **Name of referring practitioner:** |  |
| **Position:** |  |
| **Organisation:** |  |
| **I have explained the service to the patient and they agree to participate and give their consent for the sharing of relevant health information and to be contacted by the service provider via phone, email or letter.** | **Signature:** |

**EMAIL COMPLETED FORMS TO:   
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