# SFL ENROLMENT FORM

**SFL Facility Name:** _____

Name: _____ DOB: _____

Suburb: _____ Post Code: _____

Telephone: _____ Gender: _____

Email Address: _____

Country of Origin: _____ Language spoken at home: _____

Do you identify as Aboriginal or Torres Strait Islander: _____

**Referral Source:**

□ Medical Practice □ Physiotherapist □ Rehabilitation Services

□ Falls Prevention Service □ Health Clinic □ Healthy Lifestyle Program

**If self-referred, where did you hear about the Strength for life Program?**

□ Local Newspapers □ COTA SA Publication □ Friend/Family

□ Social Media □ Presentation from COTA SA □ Website

**What was the reason to start Strength Training?**

□ Medical recommendation □ Social interaction □ To improve strength

□ Preventative action □ Weight management □ To help after injury

□ Stay fit and healthy □ Chronic disease management □ Improve Balance

*I agree that information regarding my enrolment in the Strength for Life Program can be used for promotion and evaluation of the program. Information collected will be treated confidentially.*

Signed: _____ Date: _____

# PRE - ACTIVITY QUESTIONNAIRE

*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.*

Name: _____ DOB: _____

Address: _____

Telephone: _____ Mobile: _____

GP: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

**** 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 □ |

****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 □ |
| Are you being treated for osteoporosis? **Bone Density report required** | Yes □ | No □ |

****If you answered YES to one or more of the questions, directly above, you will need to consult your allied health professional (physio or exercise physiologist) instead of your Doctor, in person for a referral to SFL** (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: _____

# SFL MEDICAL REFERRAL FORM - TIER 2

Dear Strength for Life coordinator,

*I am recommending my patient undertake a supervised Strength for Life Tier 2 program that is individualised and progressive. I understand that this program will involve an accredited fitness instructor 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 and goals:

_____

_____

3. Restrictions:

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**REFERRAL DETAILS:**

Medical Practitioner Name: _____

Organisation / Facility: _____

Address: _____

Phone Number: _____ Email: _____

Providers Signature: _____ Date: _____