Referral Form

ROCHDALE BOROUGH COUNCIL

By completing your personal information below, you consent to your details being shared with Rochdale Borough Council and Your Trust to enable us to offer the right services to you. We are committed to keeping your personal information safe. View Rochdale Borough Council's Privacy Policy at www.rochdale.gov.uk/information-data-governance/privacy-cookies-data-protection and Your Trust's Privacy Policy at www.yourtrustrochdale.co.uk/privacy-policy

Personal Details

Name:

Address:

Postcode:

Date of Birth:

Telephone Number: Home:

Mobile:

Email Address:

How would you describe your gender?

- ☐ **Male** (including transgender men)
- ☐ **Female** (including transgender women)
- ☐ **Prefer to self describe as:** (non-binary, gender-fluid, agender, please specify)
- ☐ **Prefer not to say**

Please share your pronouns. (Pronouns are the part of speech used to refer to someone in the third person).
We want to know how to respectfully refer to you!

- ☐ **He/Him/His**
- ☐ **They/Them/Theirs**
- ☐ **She/Her/Hers**
- ☐ **Other** (please specify)

Are you currently a member of Your Trust? ☐ **Yes** ■ **No**

Emergency Contact Details

Name:

Relationship To You:

Telephone Number: Home:

Mobile:

Continued overleaf

Medical Conditions Please tick if you suffer from any of the conditions below

☐ **Heart Disease** (please add details in notes)	☐ **Pre-Diabetes**
☐ **Angina**	☐ **Diabetes Type 1**
☐ **High Cholesterol**	☐ **Diabetes Type 2**
☐ **High Blood Pressure**	☐ **Dizziness**
☐ **COPD**	☐ **Depression**
☐ **Asthma**	☐ **Anxiety**
☐ **Back Problems**	☐ **Parkinsons**
☐ **Epilepsy**	☐ **Multiple Sclerosis**
☐ **Joint Replacement**	☐ **Stroke**
☐ **Rheumatoid Arthritis**	☐ **Disability** (please add details in notes)
☐ **Osteoarthritis**	☐ **BMI over 25**
☐ **Osteoporosis**	☐ **Other** (please add details in notes)

Additional Medical Information

Continued overleaf

Medical Conditions - Continued

Blood Pressure (If known):	**Height** (If known):	**Weight** (If known):

Hospitalisation, surgery or physiotherapy within the last 6 months or recent illness?

Have you had a fall in the last 6 months?

Current Investigations/Awaiting test results?

Do you have any special requirements? (If yes, please give further information)

Do you have any allergies? (If yes, please give further information)

Can you think of any other medical reason why you are unable to take part in these sessions? (If yes, please give further information)

Doctors Name:	**Surgery:**	**Telephone Number:**

Agency Referral Details (To be completed by the Referring Agency)

Agency Name:

Name of Referrer:

Telephone Number:

Contact Email:

Exercise option preferred:

Declaration of Participant

I declare that to the best of my knowledge, I have completed the details in this form correctly. I am aware that, should any of these details change at any time, I should inform the instructor of the session of these changes.

Print Name:	**Signed:**	**Dated:**

Please submit your completed referral form to **exercise.referrals@rochdale.gov.uk**
For further information, please contact **01706 923685**

Partner

yourtrust