Midlothian Active Choices

Refer to guidance notes to ensure that this patient is suitable for referral.
This referral is valid for 3 months.

Patient Details
Name:

Address:

Tel No: DOB:

GP Details
Name:

Address:

Tel No:

Referral Indication (please tick)

Obesity (BMI >30) ☐
Mild/Moderate Mental Health Problem ☐

Relevant Medical History

Please give details of condition(s) and treatment(s):

_____

_____

_____

_____

Is your patient currently prescribed any medication? Please give details or attach list.

_____

_____

Baseline Measures

Weight:_____

BMI:_____

BP:_____

Activity Preference

Cycling ☐
Gym ☐
Fitness Classes ☐
Walking ☐
Swimming ☐
Gardening ☐
Other (Please detail) ☐

_____

Does your patient have any other limitations that would require consideration prior to them participating fully in any physical activity?
Please give details.

_____

_____

Declaration
The information supplied here is current and full permission has been granted by the patient to pass on this information.

Health Professional

Signature _____

Print Name_____ Date_____

Please send this referral to:
FAO Isabel Lean
C/o Heather McDonald
Midlothian CHP
Eastfield Medical Centre
Penicuik

The information provided in this form will be held securely in accordance with the Data Protection Act and will only be used by authorised staff in the development of an activity action plan. We will not share your data with anyone else except in a medical emergency. We may process your data for statistical purposes but all data will remain anonymous.