

SLL GP Referral



Please note, this form is for patients in Stevenage, North Hertfordshire and Rutland.

Those looking to join Central Bedfordshire's scheme, please disregard this form and contact the centres directly.

First name: _____ Surname: _____ Gender: _____

DOB: _____ Mobile: _____ Daytime tel: _____

Address: _____

_____ Postcode: _____

GP: _____ GP practice: _____

Please state if the patient has any of the following contraindications to physical activity, if yes the patient will not be eligible to join the scheme.

- | | | |
|--|---|---|
| <input type="radio"/> Unstable Angina | <input type="radio"/> Uncontrolled Diabetes | <input type="radio"/> Recent acute soft tissue injury |
| <input type="radio"/> Systolic Blood Pressure 180mm/Hg at rest | <input type="radio"/> Diastolic Blood Pressure 100mm/Hg at rest | |
| <input type="radio"/> Uncontrolled Tachycardia 100bpm at rest | <input type="radio"/> Unstable or acute heart failure | |

Reason for referral: ☐ Inactive

AND please tick at least one of these other criteria

- | | | | |
|--|--|--|---|
| <input type="radio"/> Controlled Hypertension | <input type="radio"/> Osteoporosis | <input type="radio"/> Smoker | <input type="radio"/> Controlled Diabetes |
| <input type="radio"/> Unhealthy Weight (BMI>28) | <input type="radio"/> Stroke | <input type="radio"/> Osteoarthritis/ Rheumatoid Arthritis | |
| <input type="radio"/> High Cholesterol Levels | <input type="radio"/> Cancer | <input type="radio"/> Mild to Moderate Mental Health Condition | |
| <input type="radio"/> Musculoskeletal Rehabilitation | <input type="radio"/> Heart Disease | <input type="radio"/> COPD | |
| <input type="radio"/> Back Pain | <input type="radio"/> Other (please state) _____ | | |

Medication:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Blood Pressure: Systolic: _____ Diastolic: _____

Additional comments/ Relevant conditions:

Healthcare Professional Declaration:

I am not aware of any contra-indication to physical activity for this referred patient.

Print name: _____ Profession: _____ Date: _____

Patient informed consent:

I have had the scheme explained to me, I agree to participate and give my consent for the sharing of relevant health information about myself between the appropriate healthcare and exercise professionals. I consent to the above information being held on a database.

Print name: _____ Profession: _____ Date: _____

Important patient information; contact:

Stevenage Arts and Leisure Centre
Stevenage Swimming Centre

[Chris Tillbrook](#)

Health and Wellbeing Consultant
01438 242 601 | chris.tillbrook@sll.co.uk

Hitchin Swimming Centre & Archers Gym
North Herts Leisure Centre, Letchworth
Royston Leisure Centre

[Laura Cragg](#)

Exercise Referral Co-Ordinator
07535 889 623 | laura.cragg@sll.co.uk

Knights Templar Sports Centre, Baldock

[Hannah Walter](#)

Exercise Referral Co-Ordinator
01462 631 300 | hannah.walter@sll.co.uk

Catmose Sports Centre, Oakham

[Amy Hammond](#)

Exercise Referral Co-Ordinator
01572 490 030 | amy.hammond@sll.co.uk

If you are looking to join a Central Bedfordshire Centre, please email the contacts below:

Sandy Sports Centre
Saxon Pool & leisure Centre
Houghton Regis Leisure Centre

Please disregard this form and contact:

[Louise Orrow](#)

Louise.orrow@centralbedfordshire.gov.uk

Flitwick Leisure Centre
Tiddenfoot Leisure Centre
Silsoe Community Sports Centre

Please disregard this form and contact:

[Loren Barnard](#)

Loren.barnard@centralbedfordshire.gov.uk

Please bring this form with you when you attend your first appointment.