Referral to Nextstep Sustainable Better Health

Patient/Client details

Title (please circle)	Mr, Mrs, Ms, Miss
First name	
Surname	
Date of birth	**/ /**
Gender (please circle)	Male/Female
Postal Address	
Postcode	
Phone	Home
	Mobile
	Work
Email	

Clinical information
1a: Does your patient currently have any of the following health conditions?
Y/ N

- ☐ Cancer
- ☐ Food allergy/intolerance
- ☐ Weight-loss surgery follow-up
- ☐ Currently pregnant or lactating
- ☐ Mental health issues
- ☐ Pancreatic disease/condition
- ☐ Lung disease/condition
- ☐ Heart disease/condition
- ☐ Kidney disease/condition
- ☐ Stomach or intestinal disease
- ☐ Liver disease/condition

Are there any other chronic diseases that we need to be aware of?
If yes please explain…………………………………………………………………………
…………………………………………………………….………………………………
………………………………………………………………………………………….....

1b: Will any of the above interfere with their ability to undertake the program? If so, how?
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………………………………………………………………………...

Section 2: Medical clearance - Doctor please select by ticking an option

☐ I consider my client is eligible, and can safely participate in the Nextstep program

☐ I consider that my client is eligible and can safely participate in the Nextstep program with the following restrictions:

……………………………………………………………………………………………
…………………………………………………………………………………………....

☐ My client is to only be on a medically supervised dietary program/exercise program until further medical clearance

I understand that the 'Nextstep' facilitator is not responsible for providing education on or monitoring compliance to the above restriction(s)____ Initials

Section 3

Doctor & Patient to choose preferred program option (please indicate which program the participant should participate in by labelling each option 1-3 with 1 being most preferred option)

Options	
14 weeks Healthy Eating Every Day (HEED) program	
14 weeks Active Living Every Day (ALED) program	
HEED and ALED programs together	

Doctor's details

Name ____

Practice ______________________________________

Division of GP _________________________________

Phone ____

Fax ____

Address ______________________________________

Practitioner Signature _________________________ Date ____________

Would you like to be updated on your clients progress at the conclusion of the program and/or if they exit the program early? Y/N

Please fax completed form to Active Ageing Australia®
Phone: 8232 9077 Fax: 8232 9020