

DOCTOR REFERRAL LETTER



Dear Living Longer Living Stronger Program™ Co-ordinator,

I am recommending my patient/client undertake a monitored Living Longer Living Stronger™ strength training program that incorporates a progressive resistance format.

TYPES OF PROVIDERS:

- Tier One** - Exercise physiologists and physiotherapists
Tier Two - Fitness professionals who have completed the Living Longer Living Stronger™ advanced training course.

ELIGIBILITY FOR REFERRAL

Anyone over 50 years of age or those over 40 years of age with a disability.

INSTRUCTIONS FOR REFERRAL

1. Those who present with three or less low level risk factors please refer to a Tier Two Provider.
2. Those with chronic conditions, injury rehabilitation needs or four or more risk factors refer to Tier One Provider.

PARTICIPANT DETAILS

Title (Miss, Ms, Mrs, Mr): _____ Name: _____
Address: _____
Suburb: _____ Postcode: _____ Phone: _____
Date of Birth: _____ Age: _____ Gender: Male Female

BLOOD PRESSURE

Blood Pressure: _____ Date Tested: _____

MEDICAL CONDITIONS

Please tick the appropriate box(es).

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Recent Surgery	<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Brain/Spinal Injury	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Neurological disorder	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Muscular pain	<input type="checkbox"/> Epilepsy/seizures
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Fall/Poor Balance	<input type="checkbox"/> Cancer	<input type="checkbox"/> Broken Bones

HEALTH HISTORY/CURRENT MEDICATIONS

Please attach a summary print out of medical history and current medications. Please elaborate in the notes if required.

NOTES

I Doctor _____ authorise _____

To undertake the Living Longer Living Stronger™ program.

Please consider the following when prescribing a training program:

1. _____
2. _____
3. _____
4. _____
5. _____

Please tick one of the following regarding your patient's progress:

- Yes, I do wish to be kept informed of the client/patient's progress
- No, I don't wish to be kept informed of the client/patient's progress

Signature: _____

Date: _____

REFERRAL TYPE (Please tick one box):

- Tier One** - classes provided by Exercise Physiologists and Physiotherapists
- Tier Two** - classes provided by Fitness Professionals who have completed the Living Longer Living Stronger™ advanced training course.
- Working Seniors Tier** - for Seniors who need to attend outside standard working hours. Patient must be capable of participating in Tier Two environments without supervision.

REFERRING ORGANISATION OR CENTRE DETAILS

Name of Medical Centre:
Address of referring Centre:
Name of person referring:
Contact numbers:
Fax number:
Email address:



FOR CLARIFICATION CONTACT

COTA (WA)
PH : (08) 9472 0104 / Fax : (08) 9253 0099
lls@cotawa.org.au