REFERRAL FOR PARTICIPATION to Exercise and Fitness after Stroke

Client Details: **DOB:**

[redacted]

Address: **POSTCODE:**

Telephone:
Next of Kin Name: **Relationship:** **Contact No.:**

[redacted]

[redacted]

Essential Referral Information

Patient has attended NHS rehabilitation service? **YES (NO (**
Date of discharge: ……**Number of sessions attended**:

Blood Pressure on Discharge: **RHR**:

6 Minute Walk: **Tinetti Score:**

)

Absolute Contra-indications

- Recent ECG changes suggesting MI
- Severe stenotic or regurgitant valvular heart disease
- Uncontrolled arrhythmia, hypertension and/or diabetes
- Unstable angina
- Third degree heart block or acute progressive heart failure
- Acute aortic dissection
- Acute myocarditis or pericarditis
- Acute pulmonary embolus or pulmonary infection
- Deep vein thrombosis
- Extreme obesity, with weight exceeding equipment capacity
- Suspected or known dissecting aneurysm
- Acute infections
- Uncontrolled visual or vestibular disturbances
- Recent injurious fall without medical assessment

NONE PRESENT ( ) (TICK TO CONFIRM)

General Medical and Stroke Medical History – (CVA dates/complications…)

Comorbidities that may contraindicate or restrict exercise or ADL's: (Circle if present)

IHD / Heart Failure / Respiratory Disease / Poor Circulation / Joint Replacements / Epilepsy

Other:

Current Medication(s) Please list all:

Patient has / is susceptible to;

Hearing impairment ( ) Impaired memory ( ) Visual impairment ( ) Impaired alertness ( )
Stroke related pain ( ) MSK Pain ( ) Shoulder subluxation ( ) Hemiparesis ( )
Arrhythmia ( ) Receptive Dysphasia ( ) Expressive dysphasia ( ) Disarthria ( )

Difficulties with body schema awareness ( ) Low tone ( ) Increased Tone ( )

Is patient able to mobilise at least 5 metres with or without a walking aid?	Yes / No
Is patient able to perform TUAG without assistance?	Yes / No
Is patient able to sit in any seat independently (time unlimited)?	Yes / No
Is patient able to mobilise one or both arms?	Yes / No
Is patient able to use one or both hands?	Yes / No
Is patient able to self monitor?	Yes / No
Is patient motivated to participate?	Yes / No
Does patient require AFO	Yes / No
Problems with static balance	Yes / No
Problems with dynamic balance activities/recovery responses	Yes / No
Has patient fallen?	Yes / No

Considerations Cautions and Recommendations for Group Exercise Participation: (and expand on any relevant responses as detailed above)

Patient Consent for Transfer of Information (in accordance with Data Protection Act 1998)
I have been informed about the exercise after stroke exercise and consent to this referral form being used. I consent to exercise professional staff processing the data for the purposes for which is was supplied.

Name:……Signed:……Date:……

Instructor Signature:……