



Move More Aberdeen Referral Form Health Professionals Form

1. Personal Details

You can self-refer to the programme using the form below: or for more info contact the Move More Aberdeen Team on: 01224 507701 or email: nhsg.movemoresa@nhs.net

Your contact details: *

Participant forename	*	<input type="text"/>
Participant surname	*	<input type="text"/>
Date of birth	*	<input type="text"/>
Postcode	*	<input type="text"/>
Telephone no.	*	<input type="text"/>

Gender *

Emergency contact *

Emergency contact name	*	<input type="text"/>
Emergency contacts telephone no.	*	<input type="text"/>
Relationship to participant	*	<input type="text"/>

Referring Health Professional

Name of Health Professional (PRINT)	<input type="text"/>
Place of work	<input type="text"/>
Designation	<input type="text"/>
Telephone	<input type="text"/>
Email	<input type="text"/>
Digital Signature	<input type="text"/>
Date	<input type="text"/>

2. Medical Details

Past medical history *

	Yes	No
Heart Conditions (e.g. heart attack)	<input type="checkbox"/>	<input type="checkbox"/>
Breathing conditions (e.g. asthma)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Neurological condition (e.g. stroke)	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Surgery (e.g. joint replacement)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing / visual difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive impairment (e.g. dementia)	<input type="checkbox"/>	<input type="checkbox"/>
Bone, muscle, joint condition (e.g. osteoporosis)	<input type="checkbox"/>	<input type="checkbox"/>
Mental health condition	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Additional comments/information that is relevant to attending Move More Aberdeen e.g. recent falls, low mood etc:

Medical diagnosis *

Date of diagnosis *	<input type="text"/>
Treatment (e.g. surgery) *	<input type="text"/>
Medication *	<input type="text"/>

Move More screening questionnaire *

	Yes	No
Has the participant's doctor ever said they have a heart condition and should only do physical activity recommended by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant feel pain in their chest when they do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, has the participant had pain in their chest when they are not doing physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant lose their balance because of dizziness or do they ever lose consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Has their doctor ever said that they have had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>

3. Participant Declaration

Sport Aberdeen is committed to protecting your right to privacy. We will only use the information that you may provide to us lawfully in accordance with The Data Protection Act 2018 and the Privacy and Electronic Communications (EC Directive) Regulations 2003. Sport Aberdeen stores all personal and sensitive information securely within the UK/EEA. Sport Aberdeen is the Data Controller. Our Privacy Policy can be found on our website www.sportaberdeen.co.uk/privacy-policy. *

Please select this box to confirm that you have read and understood our Privacy Policy

Getting in Touch We'd love to send you exclusive offers and the latest news from Sport Aberdeen. We will never sell your data and we promise to keep your details safe and secure. You can change your mind at any time. All our emails contain an unsubscribe link. "We" includes Sport Aberdeen and its trading subsidiaries Adventure Aberdeen and Aberdeen Snowsports Centre. For further details on how we look after your personal information, please read Our Privacy Policy. *

- Yes please, I'd like to hear about offers and services.
- No thanks, I don't want to hear about offers and services.

If you have selected 'Yes' to the above question then please choose how you would like to receive notifications on our offers and services. If you have selected 'No' then please choose the (N/A) option. *

- Email
- SMS (Text Message)
- Telephone
- Mail (By Post)
- N/A (None of the above)

Patient Consent

Please tick to confirm that the patient in question has given you their consent to make this referral.

- I have been given full consent by the patient