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| **ABOUT THE PROGRAM** |
| Active Measures™ provides members of the community with exercise and diet support in order to lead healthier lifestyles. Services are provided by **Accredited Exercise Physiologists (AEP)** and **Accredited Practicing Dietitians (APD)**, with Medicare and Private Health rebates available.  Exercise appointments involve education, support and an individually tailored home exercise program based on the patient’s abilities, conditions and goals. Patients are given the opportunity to purchase small sized home exercise equipment from Arche Health and are informed about appropriate ongoing community-based exercise programs.  Dietitian appointments are tailored to the individual’s requirements. The APD can advise on the dietary management of issues including but not limited to weight loss, bariatric surgery, general healthy eating, type 2 diabetes mellitus, hyperlipidaemia, hypertension, gut health/IBS, coeliac disease, anaemia and eating disorders. |

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| **REFERRING GP’S DETAILS** | | | |
| **GP Name** |  | | |
| **GP Practice** |  | | |
| **GP Signature** |  | **Date** | …….../….…./….…. |

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| **CLIENT DETAILS** | | | | |
| **Name** |  | | | |
| **Address** |  | | | |
| **Date of Birth** |  | | **Gender** |  |
| **Email** |  | | | |
| **Phone (Home)** |  | | **Phone (Mobile)** |  |
| **Private Health**  **Insurance** | □ Yes | □ No | **Fund Name** |  |
| **Emergency Contact** |  |  | **Phone** |  |

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| **SERVICES REQUIRED** | | | |
| **Service** | □ Individual dietetic services | □ Individual exercise physiology\* | |
| **\* If you have referred your patient for exercise above, you are deeming your patient medically fit to participate in light to moderate physical activity.** | | | |
| Does your patient have a GPMP and TCA in place? | | | □ Yes □ No |
| If you answered yes, have you attached a Referral Form for Individual Allied Health Services? | | | □ Yes □ No |
| Have you discussed the gap fees with your patient? The attached fee  schedule outlines the associated fees. | | | □ Yes □ No |

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| **PLEASE TICK ALL THAT APPLY** | | | | | | |
| □ Physical inactivity | | □ Current smoker | □ Osteoporosis | | |  |
| □ Hyperlipidaemia | | □ Ex-smoker | □ Osteoarthritis | | |  |
| □ Hypertension |  | □ Type 1 diabetes | □ Stroke | |  |  |
| □ Visual impairment | | □ Type 2 diabetes |  |  |  |  |
| * Heart disease/condition: * Joint or spinal condition: * Respiratory condition: * Other: Including recent hospitalisation/ surgery: | | | | | | |

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| **PATIENT’S CURRENT PHYSICAL ACTIVITY LEVELS *(please circle)*** | | | | | |
| 1. Can you walk 300m unaided? | □ Yes | | | | □ No |
| 2. How would you rate your current level of fitness? | **Poor**  1 | **Fair**  2 | **Good**3 | **Very Good Excellent**  4 5 | |
| 3. How would you rate your current level of strength? | **Poor**  1 | **Fair**  2 | **Good**3 | **Very Good Excellent**  4 5 | |
| 4. How would you rate your balance? | **Poor**  1 | **Fair**  2 | **Good**3 | **Very Good Excellent**  4 5 | |

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| **TEST RESULTS (or attach relevant copies)** | | | |
| Height | m | Total Cholesterol: | mmol/L |
| Weight | kg | Cholesterol HDL: | mmol/L |
| Waist | cm | Cholesterol LDL: | mmol/L |
| BMI (>30) |  | TG: | mmol/L |
| BSL Fasting |  | HBA1c | % |
| BSL Random |  | Blood pressure | mm HG |

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| **PATIENT CONSENT/LIABILITY DISCLAIMER** | | | |
| **ACTIVE MEASURES™ Program**  I, have enrolled in the ACTIVE MEASURES® Program offered by Arche Health Limited.  I acknowledge that my enrolment and subsequent participation is purely voluntary and in no way mandated by Arche Health Limited. In consideration of my participation in this program, I release and discharge Arche Health, its employees, directors, contractors, volunteers and agents (collectively “Releasees”) jointly and severally from all actions, causes of actions, claims and demands for, upon or by reason of any damage, loss or injury which may be sustained as a result of;   1. my voluntary participation in the program. 2. negligent or other acts caused by the Releasee(s), whether directly or indirectly connected to these activities 3. the condition of the premises where the program occurs.   This waiver shall be binding upon my heirs, executors, administrators, spouse, next of kin, guardian or legal representatives. I give consent for the Active Measures staff of Arche Health, to access and store relevant medical records of mine to assist with treating my condition and for the evaluation of the program. All information provided is treated as strictly confidential and will not be released unless required to do so by law. I give consent for the Allied Health Professionals to communicate with my GP as required. I give consent to program staff to call for an ambulance should medical assistance be required.  **I SIGN THIS DISCLAIMER VOLUNTARY FULLY ACKNOWLEDGING THAT I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS.** | | | |
| **Participant Signature** |  | **Date** |  |

***Please fax both pages of this form and any relevant Medicare or blood result paperwork to 9458 0555.***