

ACTIVE LIVES PATHWAY – REFERRAL FORM

Inclusion Criteria	Medical Exclusions (not suitable)
<p>You can be referred if you:</p> <ul style="list-style-type: none"> • Are aged 18 or over. • Are willing, motivated and ready to take part. • Are physically inactive and/or not meeting muscle strengthening guidelines • Have a stable health condition that may improve with exercise, such as: <ul style="list-style-type: none"> • Controlled high blood pressure (below 180/110 mmHg). • Stable heart disease (e.g. stable angina, past heart attack). • Controlled diabetes, mild depression, or overweight. • Have had a cardiac investigation (e.g. ECG, stress test) and are cleared by a doctor/cardiac rehab service. 	<p>You should not be referred if you:</p> <ul style="list-style-type: none"> • Are already doing regular exercise. • Are unable, not ready or not motivated to take part in a physical activity programme. • Have uncontrolled high blood pressure (above 180/110 mmHg). • If you have recently had a sudden blockage in the lungs, either from a blood clot (pulmonary embolism) or damaged lung tissue (pulmonary infarction). • Have unstable heart conditions, such as: <ul style="list-style-type: none"> • Recent heart attack (within 6 months) unless referred by cardiac rehab service. • Uncontrolled angina or arrhythmia. • Severe heart failure or valve problems. • Have not been medically cleared after a cardiac event or are awaiting cardiac investigations or treatment.



The Active Lives Pathway has three tiers of community based activities that Health and Social Care Professionals can refer into (Tiers 2-4) and signpost to DG Doing More. Tier 1 is a Clinical Pathway.

Guidance for each of the tiers is included at the back of this form or on the DG Doing More Website. More information including on Tiers and a quick and easy screening tool is also available on website.

Scan the QR code to find out more

What Tier of the Active Lives Pathway are you referring into?

All people will be contacted before starting.

Tier 2 Tier 3 Tier 4

Patient Name			
Date of Birth		Referral Date	
Patient Email	Gender		
Address including Postcode	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-binary	<input type="checkbox"/> Prefer Not to Say
	<input type="checkbox"/> My gender is not represented here. This is how I would describe my gender (please give brief details below) <input type="text"/>		
Telephone (NOTE: All referrals will be followed up by telephone.)	GP Practice Name		

How active is the patient now?			
Inactive (housebound)	<input type="checkbox"/>	Managing daily living (for example doing chores, attending appointments)	<input type="checkbox"/>
Minimum short walks (for example walk to local shops)	<input type="checkbox"/>	Low level (10 to 30 minute walk or gentle fitness class)	<input type="checkbox"/>

Primary reason for referral:

For example, to increase level of physical, to help self-manage a pre-existing medical conditions.

Increase physical activity	<input type="checkbox"/>	Improve self-management of long term condition	<input type="checkbox"/>	Improve balance	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	Preparing for an operation	<input type="checkbox"/>	Build strength	<input type="checkbox"/>
Reduce frailty	<input type="checkbox"/>	Rehab after surgery	<input type="checkbox"/>	General fitness	<input type="checkbox"/>
Other (provide information)	<input type="text"/>				

Patient medical conditions and lifestyle factors – if known (please tick all that apply)

<input type="checkbox"/> None (Tier 4)	<input type="checkbox"/> Menopause	<input type="checkbox"/> Recovery ready from problem substance use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental health condition or disability	<input type="checkbox"/> Respiratory disease
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Metabolic disease	<input type="checkbox"/> Weight loss or weight maintenance
<input type="checkbox"/> Falls prevention	<input type="checkbox"/> MSK - Musculoskeletal	<input type="checkbox"/> Inactive and/or sedentary
<input type="checkbox"/> Learning disability	<input type="checkbox"/> Neurodegenerative disease	
<input type="checkbox"/> Long Term Condition (e.g. chronic pain, long covid...)	<input type="checkbox"/> Other (please sepecify)	<input type="text"/>

Please specify exact medical condition(s) and/or lifestyle factor

Please provide brief details of how current medical conditions may affect the patient’s ability to be physically active?

Fatigue, low energy	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>
Mobility limitations	<input type="checkbox"/>	Balance / falls risk	<input type="checkbox"/>
Communication support needs	<input type="checkbox"/>	Intellectual disability	<input type="checkbox"/>
Sensory impairment (for example hearing, vision)	<input type="checkbox"/>	Mental health (for example impacting motivation)	<input type="checkbox"/>

Other (please specify)

Any additional relevant details

Name of referring practitioner	E-mail Address
Position	Organisation
Service Type (For example AHP- Rehab, GP, Social Work)	
I consent to my personal information being shared with relevant professionals within Dumfries and Galloway Health and Social Care Partnership, Dumfries and Galloway Council, Edinburgh Napier University and approved Third Sector or community organisations that are part of the Active Lives Pathway.	
The patient has been made aware that information relating to their referral will be appropriately shared with professionals from across the Health and Social Care Partnership, Dumfries and Galloway Council and approved community providers. The patient has been made aware that they may be contacted by the service provider via phone, email or letter.	
They are aware they can withdraw from a referral programme at any time by emailing Active.Communities@dumgal.gov.uk	
Signature:	

Please return completed referral form to Active.Communities@dumgal.gov.uk