Exercise Referral Standard

Guidance Document

June 2022 Issue 2

Contents

Introduction

The benefits of physical activity in health promotion and disease prevention are well documented (e.g., Ekelund et al 2016). Strong evidence now exists which shows that regular physical activity reduces the risks of acute and chronic illness such as coronary heart disease; type 2 diabetes; certain cancers; musculoskeletal disorders; and mild to moderate depression and obesity (National Institute for Health and Care Excellence: NICE, 2014; Department of Health, 2011). With one in three people in the UK currently living with a long-term health condition, physical activity promotion that is cost-effective is warranted.

What is exercise referral?

Exercise referral aims to encourage physical activity adoption to support the management and prevention of disease (NICE 2014). It involves medical practitioners and allied health practitioners, working in partnership with exercise or fitness professionals, to promote health and prevent disease at a community level. Referral into these exercise schemes provides an opportunity for an individual to access a dedicated service for the development of an affordable, tailored physical activity programme suited to their needs.

NICE (2014) define an exercise referral scheme (ERS) as having the following key characteristics:

- An assessment of an individual to determine that they are not meeting the recommended guidelines for physical activity
- A referral to a physical activity specialist or service from primary care or an allied health professional
- A personal assessment with the physical activity provider to determine a programme of activity
- An opportunity for the individual to then participate in a programme of physical activity

]. Consultation with ERS leaders, referrers, and key delivery partners in Suffolk during the development of this standard, highlighted some key challenges in the current delivery of schemes which may be replicated elsewhere. These include:

- ERS not being used at scale by eligible referrers
- A lack of awareness of ERS among GPs
- Time constraints during appointments in general practice, affecting the levels of engagement with formal referral process
- Inconsistent data collection, reporting and evaluation of schemes, making it difficult to determine impact
- Limited mechanisms for learning and sharing of best practice locally
- Variations in referral protocols, making it time consuming for those referring into schemes
- Lack of understanding whether schemes are operating in line with NICE (2014) guidelines for exercise referral.

The purpose of this document is to provide a set of quality operating standards which will address these challenges, and drive improvements in scheme delivery. The implementation of these standards will ensure ERS operate in line with NICE (2014) guidelines for exercise referral and behaviour change [see **Appendix** 1 for a summary of the guideline], and that the pathways in place for exercise referral are aligned to evidence-based principles and best practice guidelines, as well as local health and wellbeing priorities.

Who are the quality standards for?

These standards are intended for referring professionals, scheme leaders, and exercise professionals involved in the delivery of ERS. The information contained in this standard may also be useful for those in community-based coordination roles who have health and wellbeing and/or physical activity under their remit of work, and commissioners of physical activity interventions and services.

Guidance on quality standard implementation

All parties involved in the delivery of ERS are responsible for familiarising themselves with the contents of this document. To support with the achievement of the quality standards, a checklist of activities and assessment criteria are included in this document for each party directly involved in the delivery of ERS. These checklists will reflect the minimum standards required to be accredited as a quality marked scheme delivery site.

To receive the quality mark, schemes will be expected to undergo an assessment activity which will be conducted via the Quest continuous improvement process for leisure facilities and sports development teams[1]. This assessment will be based on the contents of this document and will be key to benchmarking current schemes and driving ongoing development of ERS. Leisure providers already enrolled with Quest will have the option to select the module for exercise referral as part of their existing Quest assessments. Those not yet enrolled will be able to undertake a standalone module and will not be expected to sign up for the full Quest quality scheme. Further information on this process can be found in the accompanying 'Applicant Guidance' document, or at Module Guidance - Quest (questaward.org) . **All guidelines, procedures and protocols must be adhered to meet the standard.**

[1] See https://questaward.org/

QS1 Scheme safety

Staff training and competencies

ERS **must not** operate without qualified instructors who are registered on either the professional register for exercise professionals (REPs), with a minimum Level 3 advanced instructor qualification (with exercise referral) OR with the Chartered Institute for the Management of Sport and Physical Activity with a minimum CIMSPA practitioner (exercise and fitness) membership. These instructors must also possess a current first aid award which includes cardio-pulmonary resuscitation award.

It is recognised that the qualifications and competencies of personnel delivering elements of an exercise scheme may vary, as a range of activities may need to be offered to suit participant needs and preferences i.e., health walks. Such activities will not be required to be delivered by a Level 3 instructor, however participation in these activities must be agreed by a Level 3 instructor, and anyone involved in **designing, agreeing, adapting, and reviewing** the client's physical activity programme must be REPs/ CIMSPA registered at a minimum of Level 3. The Level 3 instructor should retain overall responsibility for the client whilst participating in the scheme. They must also conduct any health or risk assessment when enrolling an individual onto an ERS.

Instructors should understand and apply core techniques of behaviour change in interactions with those participating in the ERS, in line with NICE 2014 guideline PH49 recommendations 7-10. Exercise professionals involved in the delivery of schemes can access 'making every contact count' (MECC) training to support healthy lifestyles brief intervention advice.

Additionally, exercise instructors should be able to demonstrate an understanding of the efficacy of physical activity in relation to likely health gain and/or the management of specific medical conditions.

Ensuring appropriateness of referral

Referrals into ERS are most suitable for people who are insufficiently active, and are likely to need help with motivation, exercise programming, supervision, and monitoring and/or need assistance in selecting the appropriate exercise for their abilities and health needs (British Heart Foundation, 2010). Anybody initiating a referral into an ERS should take this into consideration when deciding on the most appropriate physical activity intervention for the client.

The primary referrers into ERS should be medically trained professionals, or other allied health professionals including.

- GPs and Practice nurses
- Community nurses and health visitors
- Specialist nurses
- Hospital consultants
- Physiotherapists
- Occupational therapists
- Dieticians
- Mental health professionals

- Community pharmacists
- Cardiac rehabilitation teams

Schemes may also accept self-referrals or referrals from other public sector or community-based organisations, providing the risk protocols and procedures in this quality standard are adhered to.

Health professionals referring into ERS should ensure there is a meaningful transfer of health information to the exercise professional. In deciding what to share, the referrer should make a professional judgement as to what information should be disclosed to enable the safe and effective design of an exercise programme that is tailored to individual needs and ability.

To aid this process, each ERS should provide an appropriate referral form which can be used by health professionals, which outlines the information required for the safe and effective delivery of the exercise programme. This should include:

- Reason for referral
- Relevant current and past health conditions
- Any medications being taken and known impact on everyday functional ability
- A privacy statement and patient consent to share information

A template referral form is included in **Appendix 2.** To achieve the standard, schemes should ensure that they are either utilising this referral form, or that they have reviewed their existing referral forms to ensure they reflect the data categories included in the Suffolk Quality Standard referral form.

When an individual is referred for exercise by the health professional, responsibility for the safe and effective management, design and delivery of the exercise programme lies with the exercise and leisure professionals. The health professional maintains overall clinical responsibility for the patient. Exercise professionals involved in the delivery of the ERS should be members of either the professional register for exercise and fitness (England)[2] or the Chartered Institute for the Management of Sport and Physical Activity (CIMSPA)[3] and should be covered by organisational/ professional indemnity insurance.

Patient eligibility criteria

The following patient eligibility criteria have been formulated based on the British Heart Foundation exercise referral toolkit (British Heart Foundation, 2010) and NICE 2014 guideline for exercise referral. To follow best practice and ensure participants' safety, these criteria should be adhered to when determining participant suitability for ERS.

To meet the criteria, individuals must be:

- 16+ years old[4]

[2] http://www.exerciseregister.org/
[3] https://www.cimspa.co.uk/join
[4] Note that for individuals under 19 years of age, CMO guidelines for children and young people should be used to determine suitability for the scheme. Schemes may accept participants younger than 16 years old, however standards for working with these individuals lie outside of the scope of this quality standard.

- Participating in less than 30 minutes of moderate/vigorous physical activity (MVPA) on less than 5 days a week i.e., not meeting Chief Medical Office guidelines (2011) for physical activity
- Sufficiently motivated to want to increase their participation in physical activity

AND

- Should have an existing health condition or other factors which put them at increased risk of ill-health. (Please see **Appendix 3** for a list of recommended populations for participation in ERS)

Scheme managers should also take into consideration issues of equity and social exclusion, and may wish to prioritise participants who are from groups most affected by health inequalities.

Exclusion criteria

If individuals present with any of the following contra-indications to physical activity[5], then they should **NOT** be accepted onto the ERS:

Contraindications to physical activity
A. Febrile illness B. Uncontrolled diabetes C. Severe or Acute psychiatric illness D. Uncontrolled cardiovascular conditions (such as uncontrolled hypertension, unstable angina, rhythm disturbance, heart failure) E. Hypertrophic Cardiomyopathy (HOCM) F. Any other condition which is unstable or uncontrolled

In circumstances where an ERS is delivered by an exercise professional who has specialist qualifications (minimum Level 4) which permit them to work with specified high-risk populations, participants can be accepted onto a scheme, but **only** with final agreement and signed confirmation from a clinically trained health professional.

Assessment and risk management

All people who are referred should undertake a pre-exercise assessment which involves understanding any health or medical history, medications, and any contraindications to physical activity. This should include the use of a Health Commitment Statement to outline patient responsibilities, and a PAR-Q questionnaire [**see Appendix 4**]. If the referred individual answers 'yes' to any of the PAR-Q screening questions, further exploration of health conditions should be undertaken, and subsequent risk stratification should be carried out using the Irwin-Morgan risk stratification tool covered in the exercise referral instructor (Level 3) training [see **Appendix 5)**.

In managing the risk associated with participation in the exercise programme, ERS should only work with patients falling into the 'low' and 'medium' risk stratification categories as per the Irwin Morgan

[5] Adapted from the NHS Health Scotland Physical Activity Pathway (2013) - http://www.healthscotland.com/uploads/documents/20415-QuickReferenceGuide.pdf

stratification guide (**Appendix 5**) the following protocols relating to obtaining health information should also be applied:

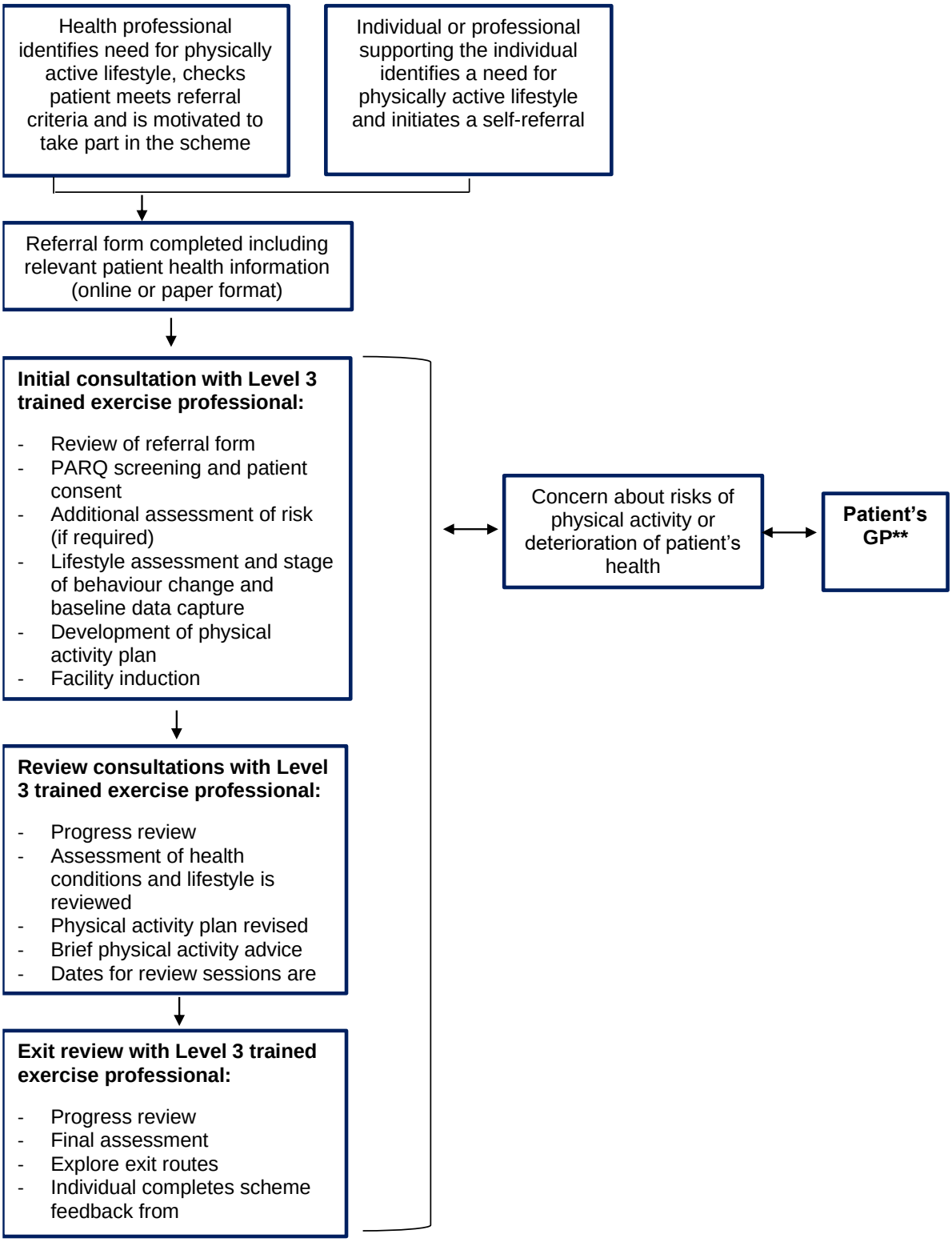
- **Low-risk patients** – providing the above risk assessment processes have taken place, individuals may be accepted onto ERS without formal sign-off or transfer of health information from the health professional. Individuals should be made aware of their responsibilities for disclosing their health condition and in participating in the scheme using a health commitment statement (**Appendix 6**). All participants should sign a disclosure to confirm their understanding. If there is any uncertainty concerning the risk of participating in exercise, medical advice should always be sought.

- **Medium risk patients** – Efforts should be made to ensure all the relevant health information is recorded in the patient referral document. In cases where medical information cannot be obtained, or where obtaining medical information may present as a barrier for participating in an ERS, decisions should be made on an individual basis whether there is enough information to design and deliver a safe and effective exercise programme. If there is any uncertainty concerning the risk of participating in exercise, individuals should not be admitted onto an ERS without obtaining the necessary health information and liaison with a qualified health professional. Medium risk patients must be entered into an individualised, supervised exercise programme relevant to their condition.

- **High-risk patients** – patients **should not** be accepted onto an ERS unless there are appropriately trained exercise professionals (minimum level 4), and final sign off from a medically trained professional. Where a relevantly trained professional is not available, the patient should be referred to the referring healthcare professional to be referred to specialised exercise rehabilitation.

QS2 Example Scheme Delivery

Example Delivery pathway and framework for delivery



The ERS should have a clear framework in place for delivery which demonstrates the different activities and processes, and how these contribute to the aims and objectives of the scheme.

ERS should run for a minimum duration of 12 weeks and should include an initial consultation or induction to establish patient preferences and goals. The exercise professional should ensure that consent is obtained from the patient prior to undertaking the consultation and commencing the activity plan. During this consultation, a pre-exercise assessment should be conducted to establish a baseline from which to monitor improvements and evaluate progress. This assessment must incorporate key behaviour change principles to select appropriate styles and motivational strategies to support an individual towards an independent and physically active lifestyle. Baseline data should be captured and recorded in line with the evaluation framework set out on pages 11 and 12 below and efforts should be made to ensure this process is person-centred and motivational.

An individual's progress should be monitored periodically, through conducting **at least one** review session (preferably at mid-point of the exercise programme) to assess progress, review the exercise programme and revisit goals. It is recommended that any individuals who fail to attend **at least 2 weeks** of sessions for an unknown reason should be followed up and the reason for non-attendance recorded. A review should also be carried out on exiting the ERS to discuss exit routes and progress. Exit routes should be suited to individual needs and preferences. A range of opportunities which are both facility and non-facility based should be discussed, and exercise professionals should be aware of local physical activity opportunities and support groups and discuss these with patients when considering individualised exit routes. The patient should also be advised of the possibility of a follow up contact or consultation during the exit consultation.

The exercise programme should be designed and agreed in consultation with the patient, and a range of opportunities and activities – both individual and group based – should be explored to ensure the programmes meets the needs and preferences of the individual.

All ERS should have clear, documented operational procedures, roles, responsibilities, and lines of accountability for all staff and partners contributing to the delivery and evaluation of the scheme. This should include periodic instructor and coordinator team meetings to discuss the delivery of the scheme, any issues and highlight areas for improvement.

QS3 Provision and sharing of information

All parties contributing to the delivery of an ERS should adhere to all appropriate data regulations and be able to meet the requirements of the General Data Protection Regulation (GDPR) 2018. This should include all policies and procedures including data storage, processing, consents, privacy notices and information sharing. In delivering an effective exercise scheme, the need to share information with external organisations may be identified. In these circumstances, valid information sharing agreements should be put in place to facilitate the safe and effective processing of personal information.

ERS leaders should ensure that the information they provide to clients and partners, and the way that it is communicated, is at an appropriate level for most of the population to understand. Any printed material should be written in plain English. Individuals participating in the ERS should be able to understand and act on health information and advice given to them throughout the duration

of an ERS, which may require the provision of information in different formats to suit individual need, and the exercise professional using communication techniques to check understanding. The Health Education England health literacy toolkit can be used as a guide to support the provision of accessible information.

QS4 Scheme monitoring and evaluation

ERS should undertake essential process and outcome evaluation at baseline, during, and at the end of the referral period, and should collect essential outcome data at the appropriate follow up points after the referral period. Monitoring and evaluation data should be collected and collated on an ongoing basis and should directly reflect the aims and objectives of ERS schemes All ERS should also have clearly defined and measurable outcomes which directly relate to the programme aims and objectives. To support this, ERS should follow a similar framework as shown in the example evaluation framework shown in **Figures 2 and 3** below.

ERS managers should ensure that the quality and performance of their scheme by analysing data collected at regular intervals. Evaluation of data will ensure that schemes reflect ERS ambitions and ensures compliance with NICE guidelines for ERS (requiring data be collected and reported in line with the essential criteria outlined in the Standard Evaluation Framework (SEF) for Physical Activity Interventions (National Obesity Observatory, 2012).

Figure 2:

BASELINE	DURING THE SCHEME	12 WEEKS	12 MONTHS	REPORTING
ESSENTIAL: PROCESS + OUTCOME EVALUATION				
Process Participant characteristics • Age • Gender • Ethnicity • Disability • First 3 characters of postcode Reason for referral i.e., existing health condition or health risk Source and quality of referral **Outcome** PA Behaviour regulation Wellbeing Physical activity levels	Service utilisation • Scheme uptake (no. of clients recruited) • Attendance rates (no. of clients attending each session; no. of clients responding at each follow up) • Adherence/ drop out	Participant satisfaction PA Behaviour regulation Wellbeing Physical activity levels	PA Behaviour regulation Wellbeing Physical activity levels	Summary of results compared to baseline Limitations and generalisability of results Recommendations for future schemes Communication of results

Figure 3

Aim: To improve and maintain the health and wellbeing of adults, through supporting sustainable increase in physical activity among those who possess or are at risk of developing long-term conditions
Objective 1 The exercise referral schemes are being used appropriately by referrers, and schemes are reaching the intended populations
1) Analysis of monitoring data including number of referrals; source of referral; quality of referral, participant characteristics; reason for referral (Quantitative)
Objective 2 The scheme is being delivered effectively and to a high-quality
1) Analysis of scheme use data including participant adherence/ dropout; scheme uptake and attendance rates (Quantitative) 2) Analysis of participant feedback (Qualitative)
Objective 3 The scheme is producing sustainable increases in physical activity and encouraging long-term behaviour change
1) Analysis of the International physical activity questionnaire (IPAQ) short scale data at baseline, post-intervention, and 12 months (Quantitative) 2) Analysis of behavioural regulation in exercise using BREQ-3 questionnaire (quantitative)
Objective 4 Participants understand the benefits of an active and healthy lifestyle and are more engaged with local opportunities to become physically active
1) Analysis of behavioural regulation in exercise using BREQ-3 questionnaire (quantitative) 2) Analysis of participation in physical activity opportunities (Quantitative) 3) Analysis of WEBWEMS wellbeing questions
Objective 5 There is evidence of reductions in the health risks associated with key long-term or life debilitating health conditions
1) Analysis of IPAQ data at baseline, post-intervention, and 12 months (Quantitative) 2) Analysis of lifestyle behaviours post-intervention and at 12 months (Quantitative)

Implementation checklists

Example Referrer checklist

✓ Need for physical activity identified and brief physical activity intervention conducted
✓ Referral form is completed with all relevant health information and is transferred in an appropriate way to the exercise professional (where appropriate)
✓ Consent to transfer information to the exercise professional is sought and patient is made aware of the information being transferred and the process of referral
✓ (For healthcare professionals) patient is informed about any symptoms that might indicate that the exercise programme is unsuitable
✓ Should the patient's health status change, the leisure provider is notified of any relevant change in health of the referred patient
✓ Physical activity clearance or a change in health form is completed if/when issued and is returned to the exercise professional

Example Leisure Provider checklists

Safety
✓ The scheme is operated by appropriately trained professionals who hold relevant qualifications and valid professional indemnity insurance. (Those involved in the **design** and **monitoring** of schemes, and exercise professionals who conduct pre-exercise consultations, should hold a Level 3 instructor qualification with exercise referral and should be registered with either REPs or CIMSPA at the appropriate level)
✓ An appropriate pre-exercise health assessment is conducted prior to designing the exercise programme (Effective use of the Suffolk template for initial assessment will ensure this standard is met)
✓ The scheme can demonstrate that participants' goals and preferences are recorded and considered in the design of the exercise programme
✓ The pre-exercise assessment includes the use of a health commitment statement and effectively uses the PAR-Q to determine suitability for exercise
✓ Further risk-stratification is undertaken for those who screen positively on any of the PAR-Q questions and there is evidence that extra risk mitigation is carried out for those patients who categorise as medium- or high-risk i.e., further liaison with health professional or alteration of exercise programme/ allocation to more specialist staff/ onward referral/ rejected from scheme

✓ The process of referral incorporates a mechanism for referring healthcare professionals to relay relevant health information to inform the design of a safe and effective exercise scheme
✓ At least one exercise professional on duty during each session of the scheme holds a current First Aid award which includes cardio-pulmonary resuscitation award

Delivery
✓ There is a clear framework in place for the delivery of the exercise scheme with clearly defined roles, responsibilities, outcomes, and objectives
✓ Scheme accessibility is supported through a range of referral pathways involving external partner organisations
✓ Staff are trained in motivational interviewing and understanding behaviour change, and can evidence the application of these techniques in practice
✓ Instructor and coordinator team meetings are held to discuss programme performance and highlight areas for improvement
✓ The patient is involved in the design and agreement of the exercise programme and delivery is tailored to individual health status, goals, and preferences
✓ An appropriate range of exercise opportunities are offered which encourage long-term exercise adherence
✓ The scheme involves appropriate monitoring of patient progress, with reviews carried out at least pre-, mid-, and post- programme, and there is evidence that the patient's goals and needs are revisited to ensure the exercise programme remains suitable and effective
✓ Where possible, the referring health professional is informed about their patient's progress upon programme completion or in the event of a change in health status or ability to participate
✓ At week 12 (programme completion), participants' progress is reviewed and appropriate exit routes to remain physically active are discussed
✓ Participants who fail to attend are identified and followed up, and where possible reasons for non-attendance are recorded

Information sharing and the provision of information
✓ A Data protection policy is in place which is GDPR compliant, and staff are aware how to access it
✓ Participant data is kept confidential, records are stored on a secure database and paper copies are stored securely
✓ There is an appropriate referral form which includes a participant privacy notice that clearly outlines who information will be shared with and patient responsibilities in relation to their participation in the scheme

Scheme monitoring and evaluation
✓ Participant attendance registers are administered at each session to monitor levels of attendance
✓ A secure database management system is in place for the storage of participant information
✓ Information is collected in line with the Suffolk Quality standard evaluation framework and includes participant measures for pre-, middle, and post-programme
✓ An agreed mechanism is in place for patient 12-month follow up i.e., scheduled follow up time, system reminders
✓ Data collected is shared securely with the Leeds Beckett University (LBU) research team on an annual basis
✓ The collection of participant information and evaluation data is participant-centred and used to motivate participants to change behaviour
✓ A culture of capturing and sharing learning to drive continuous improvement is actively promoted

References

British Heart Foundation National Centre for Physical Activity and Health (2010), A toolkit for the design, implementation, and evaluation of exercise referral schemes: http://www.ssehsactive.org.uk/exercisereferral/index.html

Department of Health, T. (2011). Start Active, Stay Active A report on physical activity for health from the four home countries' Chief Medical Officers. Retrieved from https://www.sportengland.org/media/2928/dh_128210.pdf

Ekelund U, Steene-Johannessen J, Brown WJ, Fagerland MW, Owen N, Powell KE, Bauman A, Lee IM, Series LP, Lancet Sedentary Behaviour Working Group. Does physical activity attenuate, or even eliminate, the detrimental association of sitting time with mortality? A harmonised meta-analysis of data from more than 1 million men and women. The Lancet. 2016 Sep 24;388(10051):1302-10.

Health Education England, Health literacy 'how to' guide, accessed February 2018: https://www.hee.nhs.uk/sites/default/files/documents/HL%20%E2%80%98how%20to%E2%80%99%20guide%20FINAL.pdf

National Institute of Health and Care Excellence (2014) Public Health Guideline [PH54] *Physical activity: exercise referral schemes,* Accessed online at: https://www.nice.org.uk/guidance/ph54

National Obesity Observatory (2012) Standard evaluation framework for physical activity interventions, Accessed online at: http://webarchive.nationalarchives.gov.uk/20170110171012/https://www.noo.org.uk/core/frameworks/SEF_PA

Angus, C et al (2017) Suffolk Physical Activity Needs Assessment, Joint Strategic Needs Assessment, Public Health Suffolk. https://www.healthysuffolk.org.uk/uploads/2017-10-12_Needs_assessment_Final.pdf

Appendices

APPENDIX 1: Summary of NICE 2014 guidelines [PH54] physical activity: exercise referral schemes

Exercise referral for people who are sedentary or inactive but otherwise healthy

Recommendation 1

Policy makers and commissioners should **not** fund exercise referral schemes for people who are sedentary or inactive but otherwise apparently healthy.

Primary care practitioners should **not** refer people who are sedentary or inactive, but otherwise apparently healthy, to exercise referral schemes.

Exercise referral for people who are sedentary or inactive and have a health condition or other health risk factors

Recommendation 2

Policy makers and commissioners should only fund exercise referral schemes for people who are sedentary or inactive and have existing health conditions or other factors[1] that put them at increased risk of ill health if the scheme:

- Incorporates the core techniques outlined in recommendations 7–10 of 'Behaviour change: individual approaches' NICE public health guidance 49 This includes:
    - recognising when people may or may not be more open to change (see recommendations 8 and 9)
    - agreeing goals and developing action plans to help change behaviour (see recommendation 7)
    - advising on and arranging social support (see recommendations 7 and 10)
    - tailoring behaviour change techniques and interventions to individual need (see recommendation 8)
    - monitoring progress and providing feedback (see recommendations 7 and 10)
    - developing coping plans to prevent relapse (see recommendations 7 and 8).
- Collects data in line with the 'essential criteria' outlined in the Standard Evaluation Framework for physical activity interventions. Specifically: programme details, evaluation details, demographics of individual participants, baseline data, follow-up data (impact evaluation) and process evaluation.
- Makes the data collected available for analysis, monitoring, and research to inform future practice.

Primary care practitioners should only refer people who are sedentary or inactive and have existing health conditions or other factors[1] that put them at increased risk of ill health to an exercise referral scheme if it conforms to the above criteria.

Collating and sharing data on exercise referral schemes

Recommendation 3

Public Health England should develop and manage a system to collate local data on exercise referral schemes. This system should:

- be based on the essential criteria outlined in the Standard Evaluation Framework for physical activity interventions (see recommendation 2)
- make these data available for analysis and research to inform future practice.

APPENDIX 2: Example template referral form

Referral for Exercise

PATIENT/CLIENT DETAILS

Surname: …… Forename: ……

Tel no: …… Mobile no: ……

Email: ……

Over 16 years of age: Yes No

Primary reason for referral:

GP/REFERRER DETAILS

GP/ Practitioner name: …… Contact no: ……

Practice/ organisation name & address ……

……

KNOWN MEDICAL CONDITIONS (Please tell us about any known medical conditions which may affect a patient's ability to exercise. Failure to provide this information may slow down the referral process)

	Heart attack		Mental health condition
	Hypertension		Dizziness/ falls
	Diabetes		Rheumatoid arthritis/ osteoarthritis
	Asthma		Other (please specify) ……

MEDICATION (Please provide details of medication taken by the patient which the exercise instructor should be aware of when designing the patient's exercise programme)

Referrer's Name (printed):……

Referrer's Signature: …… Date: ……

The information provided on this form will be shared with an exercise professional at your local leisure facility and will be used to help them to design a safe and effective exercise programme. Please sign below if you are happy for this information to be shared:

Patient Signature: ……

STAMP OF ORGANISATION
Stamp/print name of referring organisation

APPENDIX 3: Recommended populations for ERS

These populations have been selected based on evidence of risk reduction associated with physical activity and are meant as a guide for targeting ERS. These have been selected based on research undertaken as part of the 2017 Suffolk Physical Activity Needs Assessment (Angus, C. et al, 2017).

- High BMI
- Cardiovascular disease
- Musculoskeletal conditions
- Diabetes (controlled)
- Mild to moderate depression or anxiety
- Dementia (controlled)

Appendix 4: Example Physical Activity Readiness Questionnaire (PAR-Q)[6]

2018 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it ***does not limit your current ability*** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

☑ **If you answered NO to all of the questions above, you are cleared for physical activity.**
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION
If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness centre may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at **www.eparmedx.com** before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

 1 / 4

01-11-2017

[6] Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

APPENDIX 5: Sample Irwin Morgan risk stratification tool[7]

The Irwin and Morgan Risk Stratification Tool takes the form of a simple traffic light system, the categories of risk are demonstrated below:

LOW RISK

Overweight	No complications
High normal blood pressure	(130-139/85-89) not medication controlled
Deconditioned	Due to age or inactive lifestyle
Type 2 diabetes	Diet controlled
Older people aged >65	No more than 2 CHD risk factors and not at risk of falls
Antenatal	No symptoms of pre-eclampsia / no history of miscarriage
Postnatal	Provided 6/52 check complete and no complications
Osteoarthritis	Mild where physical activity will provide symptomatic relief
Mild bone density changes	BMD >1SD and <2.5 SD below young adult mean
Exercise induced asthma	Without other symptoms
Smoker	One other CHD risk factor & no known impairment or respiratory function
Stress/mild anxiety Seropositive HIV	Asymptomatic

MEDIUM RISK

Hypertension Stage 1	(140-159/90-99). Medication controlled
Type 2 diabetes	Medication controlled
Type 1 diabetes	With adequate instructions regarding modification of insulin dosage depending on timing of exercise and warning signs
Physical disabilities	No other risk factors
Moderate OA/RA	With intermittent mobility problems
Clinical diagnosis Osteoporosis	BMD -2.5 at spine, hip or forearm or _> 4 on Fracture index, with no history of previous low trauma fracture
Surgery – Pre and Post	General or Orthopaedic. Not Cardiac.
Intermittent claudication	No symptoms of cardiac dysfunction
Stroke/TIA	>1 year ago. Stable CV symptoms. Mobile no assistance required
Asthma	Mild (ventilator limitation does not refrain submaximal exercise)
COPD	Without ventilator limitation but would benefit from optimisation of respiratory
Neurological Conditions	system mechanics and correction of physical deconditioning E.G YOUNG ONSET Parkinson's Disease (stable); Multiple Sclerosis
Early symptomatic HIV	Moderately diminished CD4 cells, intermittent or persistent signs and

[7] https://www.yumpu.com/en/document/view/24477401/645-irwin-and-morgan-sample-risk-stratification-tool

	symptoms e.g. fatigue, weight loss, fever, lymphadenopathy
Chronic Fatigue Syndrome	Significantly deconditioned due to longstanding symptoms
Depression	Mild to moderate
Fibromyalgia	Associated impaired functional ability, poor physical fitness, social isolation, neuroendocrine and autonomic system regulation in disorders.

HIGH RISK

Older people >65 years at risk of falls. Frail older people with osteoporosis and history of fracture	REFER DIRECT TO FALLS SERVICE (BMD) >-2.5 at spine, hip or forearm in the presence of one or more documented low trauma or fragility fractures). REFER DIRECT TO FALLS SERVICE
Unstable and uncontrolled cardiac disease	
Claudication with cardiac dysfunction	
Orthostatic hypotension	Fall SBP -20mg/Hg or DBP -10mg/Hg within 3 mins of standing
Stroke/TIA	Recent (>3 months ago)
Severe Osteoarthritis/Rheumatoid arthritis	With associated mobility
Type 1 or Type 2 Diabetes (Advanced)	With associated mobility
Moderate to severe arthritis	With accompanying autonomic neuropathy, advanced retinopathy
COPD/emphysema	With true ventilatory limitation
AIDS	With accompanying neuromuscular complications severe depletion of CD4 cells, malignancy or opportunistic infection
Psychiatric illness/cognitive impairment/dementia	AMT score <8

Appendix 6: Health commitment statement

HEALTH COMMITMENT STATEMENT

Your health is your responsibility. The management and staff of this organisation are dedicated to helping you take every opportunity to enjoy the facilities that we offer. With this in mind, we have carefully considered what we can reasonably expect of each other.

Our commitment to you:

1. We will respect your personal decisions and allow you to make your own decisions about what exercise you can carry out. However, we ask you not to exercise beyond what you consider to be your own abilities.
2. We will make every reasonable effort to make sure that our equipment and facilities are in a safe condition for you to use and enjoy.
3. We will take all reasonable steps to make sure that our staff are qualified to the fitness industry standards as set out by the Chartered Institute for the Management of Sport and Physical Activity and or the Register of Exercise Professionals.
4. If you tell us that you have a disability which puts you at a substantial disadvantage in accessing our equipment and facilities, we will consider what adjustments, if any, are reasonable for us to make.

Your commitment to us:

1. You should not exercise beyond your own abilities. If you know or are concerned that you have a medical condition which might interfere with you exercising safely before you use our equipment and facilities, you should get advice from a relevant medical professional and follow that advice.
2. You should make yourself aware of any rules and instructions, including warning notices. Exercise carries its own risks. You should not carry out any activities which you have been told are not suitable for you.
3. You should let us know immediately if you feel ill when using our equipment or facilities. Our staff members are not qualified doctors, but there will be a person available who has had first-aid training.
4. If you have a disability, you must follow any reasonable instructions to allow you to exercise safely.

This statement is for guidance only. It is not a legally binding agreement between you and us and does not create any obligations which you or we must meet.

Member Signature: …… Date: ……

Staff Signature: …… Date: ……