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**Lincoln City Foundation**

**Physical Activity Referral Form**

First Name:………………………………………………………………………………………….

Last Name:………………………………………………………………………………………….

Date of Birth: ……………………………………………………………………………………….

Gender:……………………………………………………………………………………………..

Telephone:………………………………………………………………………………………….

Email:……………………………………………………………………………………………….

Address:……………………………………………………………………………………………

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**Referral Details**

Self-Referral ☐

Health Care Professional Referral ☐

**Primary Reason for Referral?**

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**Referrer Contact Details**

Name ……………………………………………………………

Telephone number ……………………………………………..

Email ………………..……………………………………………………...

**Medical History**

Date of Parkinson’s Diagnosis:…………………………………..

Brief Current Medical Overview

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Brief Past Medical History

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Do you have any specific physical limitations?

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**Emergency Contact Details (ICE)**

Name:……………………………………………………………………………………………………………

Relationship to you:………………..………………………………………………………………………..…

Contact:………………………………………………………………………………………………………….

**Consent**

☐ Self-Referral Declaration - I confirm the details provided on this form are a true reflection of my current medical status. Should there be something that affects my ability to exercise, or I have a change in my medical diagnosis, I will inform the instructor immediately and stop exercising if necessary.

☐ Data Protection - We keep your records confidentially and securely. From time to time, our partners ask for information for monitoring and evaluation purposes to help us improve our service. Please tick this box if you consent to this.

☐ Filming and Photos - I understand that from time to time, photographs or filming will be taken during sessions. All such photography and filming will be carried out by a Lincoln City Foundation approved person and used to promote the programme. Please tick this box if you consent to this.

Please email to Health@lincolncityfoundation.co.uk