

# Referral form

## What is Living Longer Living Stronger?

Living Longer Living Stronger is an affordable, safe, and effective strength and balance training program for older Australians.

This referral form must be completed by a medical or allied health practitioner.

### *Referring practitioner details*

<b>Practitioner name (title, first and last names)</b> <i>Please specify the name of the referring practitioner</i>	
<b>Email address (practitioner)</b>	<b>Phone number (practitioner)</b>
<b>Practitioner, organisation or facility address</b> <i>Please provide the address of the referring practitioner, organisation or facility</i>	
Street address:	
City, town or suburb:	
State/Territory:	Postcode:

### *Patient details*

<b>First name</b>	<b>Last name</b>
<b>Date of birth</b> <i>(day/month/year)</i>	<b>Phone number</b>
/     /	
<b>Home address</b>	
Street address:	
City, town or suburb:	
State/Territory:	Postcode:

## Conditions, medications and recommendations

### Details of acute or chronic conditions and medications

Please provide details of acute or chronic conditions and medications being taken by your patient

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### Contraindicated exercises (activities that should not be undertaken)

Please outline any recommendations that you may have regarding contraindicated activities.  
I.e. exercises that your patient should not do

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### Other recommendations

Please outline any other recommendations that you may have regarding your patient's participation in the Living Longer Living Stronger program

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### Which tier of the Living Longer Living Stronger program do you recommend for your client?

Please tick the applicable option

<input type="checkbox"/>	<del>Tier 1 (delivered by exercise physiologists and/or physiotherapists)</del> Not Available
<input type="checkbox"/>	Tier 2 (delivered by fitness professionals)

**Tier 1:** participants with unmanaged chronic conditions, recovering from injury or who have multiple medical risk factors.

**Tier 2:** participants with managed chronic conditions or who have few medical risks.

### Please keep me informed about my patient's progress

Please tick the applicable option

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

### Signed

(referring practitioner signature)

### Date

(day/month/year)

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