

MEDICAL REFERRAL FORM - TIER 2

Dear Strength for life coordinator,

I am recommending my patient undertake a supervised Strength for life Tier 2 program that is individualised and progressive. I understand that this program will be monitored by a qualified fitness instructor with SFL accreditation.

CLIENT DETAILS:

Name: _____ Date of Birth: _____

Address: _____ Post Code: _____

1. The client has presented with low level of health risk factors or managed conditions:

Details of conditions/current medication:

2. Recommendations:

3. I would like to be kept informed of my client's progress Yes No

REFERRAL DETAILS:

Medical Practitioner Name: _____

Organisation / Facility: _____

Address: _____

Phone Number: _____ Email: _____

Providers Signature: _____

Date: _____