

## Bournemouth Heart Club Keep Well Hub Royal Bournemouth Hospital (F10) Castle Lane East, Bournemouth, BH7 7DW Tel: 0300 019 4522 Email: office@bournemouthheartclub.org.uk



## **Keep Well Sessions – Self Referral**

Thank you for your interest in joining the Keep Well Scheme with supervised exercise alongside existing Club Members.

Address:	Name:	e: Date of birth:			
Tel:					
Email:					
Relevant Medical Details  Relevant Medical Details  Yes/N Date diagnosed Comments  Angina Heart Failure Heart Valve Disease Hypertension Rhythm Disturbance Pacemaker Heart Attack (Stent or Bypass) Diabetes Respiratory Disease Stroke/TIA Poor Mobility					
Angina Heart Failure Heart Valve Disease Hypertension Rhythm Disturbance Pacemaker Heart Attack (Stent or Bypass) Diabetes Respiratory Disease Stroke/TIA Poor Mobility  Comments Comme					
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Angina Heart Failure Heart Valve Disease Hypertension Rhythm Disturbance Pacemaker Heart Attack (Stent or Bypass) Diabetes Respiratory Disease Stroke/TIA Poor Mobility			Relevant Medic	al Details	
Heart Failure  Heart Valve Disease  Hypertension  Rhythm Disturbance  Pacemaker  Heart Attack (Stent or Bypass)  Diabetes  Respiratory Disease  Stroke/TIA  Poor Mobility		Yes/N	Date diagnosed	Comments	
Heart Valve Disease  Hypertension  Rhythm Disturbance  Pacemaker  Heart Attack (Stent or Bypass)  Diabetes  Respiratory Disease  Stroke/TIA  Poor Mobility	Angina				
Hypertension  Rhythm Disturbance  Pacemaker  Heart Attack (Stent or Bypass)  Diabetes  Respiratory Disease  Stroke/TIA  Poor Mobility	Heart Failure				
Rhythm Disturbance Pacemaker Heart Attack (Stent or Bypass) Diabetes Respiratory Disease Stroke/TIA Poor Mobility	Heart Valve Disease				
Pacemaker  Heart Attack (Stent or Bypass)  Diabetes  Respiratory Disease  Stroke/TIA  Poor Mobility	Hypertension				
Heart Attack (Stent or Bypass)  Diabetes  Respiratory Disease  Stroke/TIA  Poor Mobility	Rhythm Disturbance				
(Stent or Bypass)  Diabetes  Respiratory Disease  Stroke/TIA  Poor Mobility	Pacemaker				
Diabetes  Respiratory Disease  Stroke/TIA  Poor Mobility	Heart Attack				
Respiratory Disease Stroke/TIA Poor Mobility	(Stent or Bypass)				
Stroke/TIA Poor Mobility	Diabetes				
Poor Mobility	Respiratory Disease				
·	Stroke/TIA				
Other (please specify)	Poor Mobility				
	Other (please specify)				
	3. Current Medication:				
3. Current Medication:					
3. Current Medication:	1. Disclaimer: I hereby o	onfirm tha	t the information s	upplied is true to the best of my knowledge	
	and I have disclosed accura	ate inform	ation relating to m	y medication and general health.	
<b>1. Disclaimer:</b> I hereby confirm that the information supplied is true to the best of my knowledge and I have disclosed accurate information relating to my medication and general health.					
4. Disclaimer: I hereby confirm that the information supplied is true to the best of my knowledge and I have disclosed accurate information relating to my medication and general health. hereby give permission that if during my assessment a concern arises with my general health that the	mormation can be referre	a to my G	r anujor the appro	priate medical specialist.	
<b>1. Disclaimer:</b> I hereby confirm that the information supplied is true to the best of my knowledge and I have disclosed accurate information relating to my medication and general health.					
4. Disclaimer: I hereby confirm that the information supplied is true to the best of my knowledge and I have disclosed accurate information relating to my medication and general health. hereby give permission that if during my assessment a concern arises with my general health that the	Sign:			Date:	

02/04/2204 - F4 Self Referral Form V11