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| Name | DOB | Hospital ID |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

|  |  |
| --- | --- |
| Email | Mobile Number |
| Click here to enter text. | Click here to enter text. |

|  |  |  |
| --- | --- | --- |
|  | Side | Joint |
| Diagnosis (OA) | Choose an item. | Choose an item. |

# MEDICAL HISTORY

Please tick the boxes to indicate if you have any of the following. Any ticked yes will be discussed in a phone call as part of the referral:

* Heart Disease YES  NO
* High blood pressure YES  NO
* Diabetes YES  NO
* Angina YES  NO
* Epilepsy YES  NO
* Fever YES  NO
* Dizziness or breathlessness during exercise YES  NO

# PATIENT CRITERIA

* Able to communicate in English without an interpreter, in a group
* Internet and video calling access
* Aged 45 years or older
* Chronic joint pain for at least 6 months
* Needing a supervised exercise programme
* Independently mobile and able to carry out regular exercise
* Available to attend classes virtually twice a week for 6 weeks

# Consent

* I agree to have my Zoom profile being visible to those within the closed group
* I understand that when I speak on the Zoom session the whole group can hear and see me and my environment
* I understand that I am responsible for how I use the information provided in the group
* I agree to not discuss information about any group members outside of the group
* I understand if I misuse the group I will be removed from the group
* I understand I use Zoom at my own risk
* I understand not to record, or take screen shots of Zoom meetings, or let anyone in my household do so - you can be reassured that the session is not being recorded by the NHS Hosts, and that the record facility has been disabled on the platform

**Disclaimer**

*“If you proceed with joining the session you are consenting to participate in the class and will see other patients. This can’t be helped however this does not mean that your personal data will or should be shared, and you are not consenting to such practice. Any questions that have, or may lead to the divulgence of, confidential information are not to be asked via this platform. By proceeding you are agreeing to keep these sessions confidential and that information is not to be shared. If you wish to join but not be seen by others, please switch off your camera and change your account name to your initials before being admitted into the session, and let staff know this is what you will be doing.”*

Name: Click here to enter text. Date: 01/09/2020

Once you have completed the referral form please return it via email to [Physiotherapy.Central@wales.nhs.uk](mailto:Physiotherapy.Central@wales.nhs.uk)

For further queries regarding the programme please contact us on **02920 335717**