Strength for Life

Live longer, live stronger

INFORMATION FORM

SFL Provider Name: _____

PARTICIPANT DETAILS

Have you previously participated in the SFL Program? ☐ Yes ☐ No

First Name: _____ **Surname:** _____

Postcode: _____ **Date of Birth:** ____/____/_____ **Gender:** ☐ Female ☐ Male ☐ Other

Country of Birth: _____

Aboriginal or Torres Strait Islander person: ☐ Yes ☐ No

Concession Card: ☐ Yes ☐ No **Do you have a disability?** ☐ Yes ☐ No

How many total minutes of exercise do you do per week? _____

PARTICIPANT CONSENT

- Participating in SFL Program is voluntary
- Your personal information will be kept confidential and all data collected will be securely stored by COTA WA for the purpose of reporting, promotion, auditing, research, evaluation and quality assurance. Please refer to the COTA WA Privacy Policy for further information: www.cotawa.org.au

Participant Signature: _____ **Date:** _____/_____/ 20_____

COTA WESTERN AUSTRALIA

COTA (WA)
The Perron Centre
Suite 2, 61 Kitchener Ave
Victoria Park WA 6100
ABN 79 970 893 100

P.O. Box 923
Victoria Park WA 6979
W: www.cotawa.org.au

T: (08) 9472 0104
F: (08) 9253 0099
E: kairi@cotawa.org.au

CITY OF MANDURAH
MARC

Strength for Life Registration

Email Address: _____

Title: ☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Other_____ First Name: _____

Surname: _____ Date of Birth: _____

Home Phone: _____ Mobile Phone: _____

Address: _____ Postcode: _____

Emergency Contact: _____ Phone No: _____

Special Conditions: _____

_____

Medical Information

Name of your regular Doctor: _____

Doctor's Address: _____

Doctor's Phone No: _____

Terms and Conditions

I hereby apply to become a participant of the City of Mandurah MARC exercise program and declare that I have returned the medical clearance forms completed by my Doctor.

I understand that I use the facilities at my own risk and to the extent permissible at law release the City of Mandurah from liability to me for injury, damage to property or person incurred by me unless such injury is done at the negligence of the City of Mandurah.

I agree to inform the City of Mandurah MARC of any change in my health that may affect my participation in the Living Longer Living Stronger program run by the Centres'.

I acknowledge and recognise the possibility of injury or other damages connected with physical activity undertaken by myself utilising the facilities or services.

Assessment with DVA Gold Card, Commonwealth Seniors Card and Senior Card Holders

Signature: _____ Date ____ / ____ / ____

Signed for and on Behalf of the City: _____ Date ____ / ____ / ____

Office Use Only:

Receipt No: _____ Barcode No: _____ Staff Initial: _____

Age at last birthday: _____ Checked By: _____

DOCTOR REFERRAL LETTER

Strength for Life
Live longer, live stronger

Dear **Strength for Life™ Co-ordinator,**

I am recommending my patient/client undertake a monitored Strength for Life™ strength training program that incorporates a progressive resistance format.

TYPES OF PROVIDERS:
Tier One - Exercise physiologists and physiotherapists
Tier Two - Fitness professionals who have completed the SFL™ advanced training course.

ELIGIBILITY FOR REFERRAL
Anyone over 50 years of age or those over 40 years of age with a disability.

INSTRUCTIONS FOR REFERRAL
1. Those who present with three or less low level risk factors please refer to a Tier Two Provider.
2. Those with chronic conditions, injury rehabilitation needs or four or more risk factors refer to Tier One Provider.

PARTICIPANT DETAILS

Title (Miss, Ms, Mrs, Mr): _____ Name: _____

Address: _____

Suburb: _____ Postcode: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

BLOOD PRESSURE

Blood Pressure: _____ Date Tested: _____

MEDICAL CONDITIONS

Please tick the appropriate box(es).

☐ Hypertension	☐ Recent Surgery	☐ Vision Impairment	☐ Heart Disease
☐ Arthritis	☐ Diabetes	☐ Brain/Spinal Injury	☐ High Cholesterol
☐ Neurological disorder	☐ Osteoporosis	☐ Muscular pain	☐ Epilepsy/seizures
☐ Chronic Fatigue	☐ Fall/Poor Balance	☐ Cancer	☐ Broken Bones

HEALTH HISTORY/CURRENT MEDICATIONS

Please attach a summary print out of medical history and current medications. Please elaborate in the notes if required.

NOTES

I Doctor_____ authorise _____

To undertake the Strength for Life™ program.

Please consider the following when prescribing a training program:

1. _____

2. _____

3. _____

4. _____

5. _____

Please tick one of the following regarding your patient's progress:

☐ Yes, I do wish to be kept informed of the client/patient's progress

☐ No, I don't wish to be kept informed of the client/patient's progress

Signature: _____ Date: _____

REFERRAL TYPE (Please tick one box):

☐ **Tier Two** - classes provided by Fitness Professionals who have completed the Strength for Life™ advanced training course.

REFERRING ORGANISATION OR CENTRE DETAILS

Name of Medical Centre:
Address of referring Centre:
Name of person referring:
Contact numbers:
Email address:

FOR CLARIFICATION CONTACT

COTA (WA)
PH : (08) 9472 0104 / Fax : (08) 9253 0099
sfl@cotawa.org.au

PARTICIPANT TO COMPLETE, INSTRUCTOR TO REVIEW

EXERCISE & TRAINING READINESS ASSESSMENT

Strength for Life
Live longer, live stronger

IMPORTANT INFORMATION: This form is used to ensure that we provide every client with the highest level of care. For most people exercise is fun, positive, and an energising pastime which improves health and leads to an enhanced quality of life. However, there are a small number of people who may be at risk when participating in an exercise program. Such risks include falls, sprains, fracture, or damage to components of the heart/ lung system. We would therefore ask that you read, and complete, this form carefully.

PERSONAL DETAILS

Name: _____ DOB: ___/___/___ Gender: ☐ M ☐ F

Address: _____

Contact numbers;

(Home): _____ (Mobile): _____ (Work): _____

Email address: _____ Occupation: _____

Private Health Insurance Fund: _____

EMERGENCY CONTACT DETAILS

Name: _____ Contact number: _____

MEDICAL DETAILS

General Practitioner: _____

Address: _____

Contact numbers: _____ Email address: _____

Where did you hear about the program?

☐ Newspaper ☐ Radio ☐ Website

☐ Other (please specify) _____

Please tick the appropriate box if you have, ever had, or are on medication for;

☐ Heart problems
☐ Discomfort in the chest at rest or exertion
☐ Epilepsy
☐ Asthma, emphysema, bronchitis - other lung problems
☐ Discomfort in the legs at rest or exertion
☐ Arthritis or major injuries in any joints
☐ Severe vein disorders in the legs, or feet, or ulcers
☐ Liver condition
☐ Kidney condition
☐ Rheumatic fever
☐ Cancer
☐ Other (please specify) _____

☐ Diabetes
☐ High cholesterol
☐ High blood pressure
☐ Stroke
☐ Hernia
☐ Osteoporosis
☐ Swollen feet/ankles
☐ Glandular fever
☐ Eating disorder
☐ Dizziness/fainting

CARDIO-PULMONARY SYSTEM

1. Do you have, or have you experienced:

☐ No ☐ Epilepsy ☐ Fainting
☐ Seizures ☐ Dizzy spells ☐ Convulsions

2. Have you ever had pain or pressure, either at rest or during exercise:

☐ no
☐ in the middle of, or on the left side of, the chest
☐ in the neck region
☐ at the left shoulder or down the left arm

3. Do you take any medications for (please specify name):

☐ No
☐ Heart disease: _____ ☐ Diabetes: _____
☐ Cholesterol: _____ ☐ Blood pressure: _____
☐ Asthma, breathing problems: _____

NEURO-MUSCULAR

4. Do you have any impairments of the following? (tick appropriate box)

☐ No
☐ Thermal (temperature control)
☐ Motor sensory
☐ Vision or hearing
☐ Speech/ language

5. Have you ever experienced a brain or spinal injury? ☐ Yes ☐ No

6. Do you have, or do you experience:

☐ No
☐ Poor balance / instability
☐ Pressure sores
☐ Unsteady gait (walking)

7. In the previous 12 months have you experienced:

☐ No
☐ Severe cramps
☐ Concussion
☐ Unexplained muscle soreness
☐ Persistent headaches/ nausea

8. Have you suffered any nervous system injury?

☐ No
☐ Lesion of, or damage to, a nerve
☐ Numbness, or pins and needles
☐ Other (please specify): _____

MUSCULO-SKELETAL

9. Have you experienced any muscular pain in the last six months? ☐ Yes ☐ No
If yes, please specify: _____

10. Have you experienced any joint pain in the last six months? ☐ Yes ☐ No
If yes, please specify: _____

11. Have you broken any bones in the last 12 months? ☐ Yes ☐ No
If yes, please specify: _____

12. Have you had any musculo-skeletal or joint problems requiring treatment or joint replacement? ☐ Yes ☐ No
If yes, please explain: _____
(Please include problem, treatment and treating physician)

13. Do you, or a blood relative, suffer from a musculo-skeletal problem, such as osteoporosis or arthritis? ☐ Yes ☐ No
If yes, please specify: _____

GENERAL HEALTH

14. Do you have any neurological disorder which may require special needs whilst exercising?
Examples may include: Parkinson's, Alzheimers, or Motor Neurone Disease, Multiple Sclerosis, Downs Syndrome, Cerebral Palsy, or Dementia, or short term memory loss.

_____

15. Are you aware of any medical reason/condition which might prevent you from participating in an exercise program? ☐ Yes ☐ No
If yes, please specify: _____

16. Do you have any allergies which may affect your capacity/ ability to exercise? ☐ Yes ☐ No
If yes, please specify: _____

17. Do you have chronic fatigue syndrome? ☐ Yes ☐ No

18. Have you had surgery in the previous 12 months? ☐ Yes ☐ No
If yes, please explain: _____

19. Is there any other medical conditions not covered that you would like us to know about?

☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

_____

_____

MEDICATIONS Please list any medication you are taking (including headache pills) and the frequency of use:

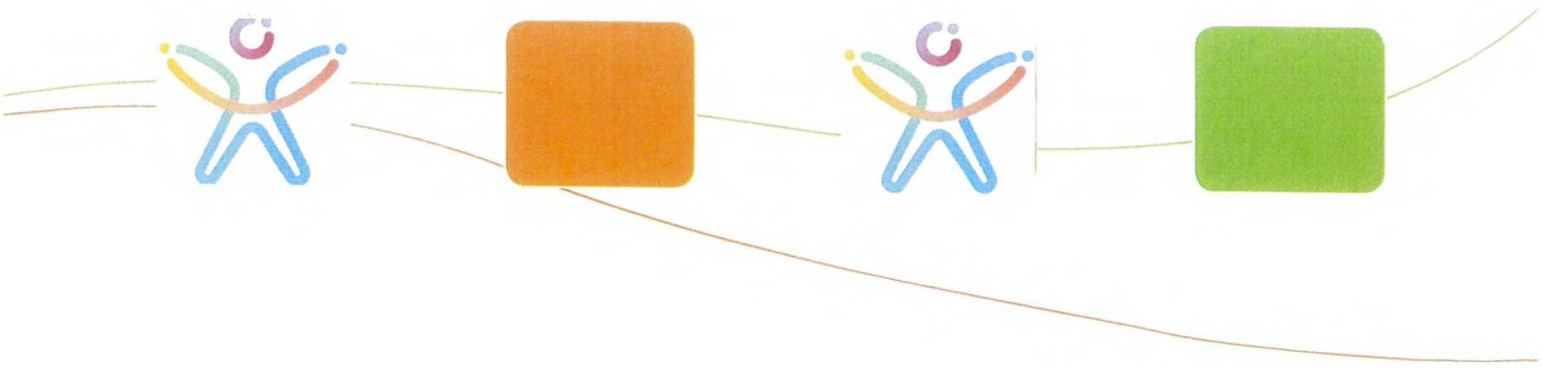
NAME OF MEDICATION/DRUG	FREQUENCY OF USE		
	Daily	Weekly	Monthly
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐
6.	☐	☐	☐
7.	☐	☐	☐

Strength for Life™ (SFL) Participants must read the following statements carefully and sign below understanding that ;

- I understand that the SFL™ Instructor cannot give me medical advice.
- I will tell the Instructor immediately if I feel any symptoms or if my health status changes from that above
- I will consult my GP if I wish to try exercise at a different intensity from SFL™.
- I agree to follow the directions of my SFL™ Instructor in my LLLS™ exercise program and will exercise at my own pace.
- I authorise the SFL™ instructor and my GP to communicate about my progress in SFL™ and understand that they are bound by the Privacy Act and will only use information pertinent to my exercise program and medical condition as it relates to exercise.
- I understand that a copy of my SFL™ forms can be accessed by the SFL™ Project Management Team (at COTA WA Inc) for monitoring and they are bound by the Privacy Act to use this information for statistical purposes only.

I have read and understood the above statements.

Signature (SFL™ Participant): _____ **Date:** _____



PARTICIPANT TO COMPLETE, INSTRUCTOR TO REVIEW

ACTIVITIES-SPECIFIC BALANCE CONFIDENCE

Strength for Life

Name:_____ Date: _____

INSTRUCTIONS: For each of the following 12 activities, please indicate your level of self-confidence by choosing a corresponding number from the scale of 1 (Not at all confident) to 10 (Completely confident).

HOW CONFIDENT ARE YOU THAT YOU WILL NOT LOSE YOUR BALANCE OR BECOME UNSTEADY WHEN YOU...

1. Walk around the house?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

2. Walk up and down stairs?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

3. Bend over and pick up something off the floor?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

4. Reach for a small can off a shelf at eye level?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

5. Stand on your tip toes and reach for something above your head?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

6. Walking on uneven surfaces, i.e. footpath, grass, etc.?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

7. Sweep the floor?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

8. Walk outside the house to a car parked in the driveway?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident		Quite confident			Completely confident

9. Get into and out of a chair/bed?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident			Quite confident		Completely confident

10. Walk up a ramp?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident			Quite confident		Completely confident

11. Walk in a crowded shopping centre where people rapidly walk past you?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident			Quite confident		Completely confident

12. Step on or off escalator while holding onto the railing?

1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Moderately confident			Quite confident		Completely confident

YOUR ACTIVITIES-SPECIFIC BALANCE CONFIDENCE SCORE _____

SCORING (APPLIES TO ABOVE QUESTIONS 1 TO 12 ONLY)

12-24 NOT VERY CONFIDENT Balance exercises must be programmed

25-48 SOMEWHAT CONFIDENT Balance exercises must be programmed

49-72 MODERATELY CONFIDENT Balance exercises must be programmed

73-96 MOSTLY CONFIDENT Balance exercises to address problem areas

97+ COMPLETELY CONFIDENT Balance exercises are not required

Please also see the enclosed resource titled "How many of these questions do you fall down on?". Answer the questions and use the resources to see what falls prevention measures you can put in place to reduce the risk of falling. Strength for Life (formerly Living Longer Living Stronger™) and COTA (WA) would like to acknowledge the work of the WA Department of Health and Stay On Your Feet® WA program for the development of this resource.

More information can be obtained from the Stay On Your Feet® WA Resource Information Centre on 9420 7212 or by visiting www.stayonyourfeet.com.au

Strength for Life