

<b>SECTION 1</b>	Your Name:				Phone:	
	Address:					
	State:	P/code:	Sex: M / F	Age: yrs	Leader/venue:	
	Emergency Contact Name:				Phone:	
	Doctor Name:		Phone:		Fax:	
	Address:		State:		Postcode:	

<b>SECTION 2</b>	<input type="checkbox"/> <b>Tick if you are of Aboriginal or Torres Strait Islander descent:</b>		Name of your Private Health Insurance Fund:	
	<b>Heartmoves participants must read the following STATEMENTS carefully and sign below UNDERSTANDING that:</b>			
	<ul style="list-style-type: none"> <li>I understand that the Heartmoves leader cannot give me medical advice.</li> <li>I will tell the leader immediately if I feel any symptoms OR if my health status should change from that below.</li> <li>I will consult my GP if I wish to try to exercise at a different intensity from Heartmoves.</li> <li>I agree to follow the directions of my Heartmoves Leader in my Heartmoves exercise program &amp; will exercise at my own pace.</li> <li>I authorise the Heartmoves leader and my GP to communicate about my progress in Heartmoves &amp; 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.</li> <li>I understand that a copy of this form goes to the Heartmoves Management Team (at the National Heart Foundation of Australia) for monitoring, and they are bound by the privacy act to use this information for statistical purposes only.</li> </ul>			
	<input type="checkbox"/> Please tick if you do not wish to receive any information from the National Heart Foundation of Australia			

<b>SECTION 3</b>	<b>If you have read &amp; understood the above statements please sign here:</b>				_____ / ____ / ____ Heartmoves Participant Today's Date	
	<b>Please tick the appropriate box if you have, ever had, or are on medication for:</b>					
	Yes	No			Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems – heart attack, angina, palpitations, bypass, pacemaker, valves, angioplasty, etc	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Discomfort in the chest at rest or exertion	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, emphysema, bronchitis – other lung problems	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Discomfort in the legs at rest or exertion	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or major injuries in any joints	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Severe vein disorders in the legs or feet, or ulcers	Swollen feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Liver condition	Glandular Fever	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Kidney condition	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
			Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	

<b>SECTION 4</b>	<b>If any of the above are ticked "Yes", it is advised that medical clearance be obtained from your doctor prior to exercising</b>					
	<b>If you already have clearance to exercise please sign here:</b>					
	_____ / ____ / ____ Heartmoves Participant Today's Date					
	<b>To be completed by Exercise, Health and/or Medical Professional</b>					
	<b>This form was initiated by (please tick):</b> <input type="checkbox"/> Heartmoves Leader <input type="checkbox"/> GP <input type="checkbox"/> Cardiac Rehabilitation <input type="checkbox"/> Diabetes Educator <input type="checkbox"/> Dietitian <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Exercise Physiologist <input type="checkbox"/> Community Health <input type="checkbox"/> Practice Nurse <input type="checkbox"/> Specialist <input type="checkbox"/> Other: _____					
	<b>Heartmoves goal for this client:</b> _____					
	<b>Feedback requested from the Heartmoves Leader:</b> <input type="checkbox"/> Only in the event of problems <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months					
	<b>Feedback to be sent to:</b> Name: _____ Phone: _____ Fax: _____					

<b>SECTION 4</b>	<input type="checkbox"/> This client has a <b>Care Plan</b> (summary attached)		For eligibility guidelines: <a href="http://www.heartfoundation.org.au/downloads/NHF/HM_EligibilityGuidelines.pdf">www.heartfoundation.org.au/downloads/NHF/HM_EligibilityGuidelines.pdf</a>	
	<b>This client should exercise at:</b> <input type="checkbox"/> Low intensity (or seated) <input type="checkbox"/> Low-Moderate intensity <input type="checkbox"/> Moderate intensity			
	<b>This client must stop exercising if:</b> _____			
	<b>Doctor's Signature for Medical Clearance:</b> _____		<b>Today's Date:</b> ____ / ____ / ____	

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**NOTE TO HEARTMOVES LEADER:** Please forward a copy of this completed form to the Heartmoves Team instead of the pink carbon copy for the purposes of statistical monitoring. You can fax or mail a copy of the form to the Heartmoves Team on: Fax: (02 4952 4626) or mail: Heartmoves Team PO Box 334 Kotara 2289. Thank you. If you have any questions, please do not hesitate to contact us on 1300 36 27 87 or [health@heartfoundation.org.au](mailto:health@heartfoundation.org.au).

**NOTE TO GP / Health Professional:** Please complete form and give to patient to take with them to their Heartmoves Program.