

Strength for Life

Information Pack



We are delighted that you are interested in our Strength for Life program, which promotes a healthy and active lifestyle. Classes run in a group environment, using a variety of equipment, in our multi-purpose room. Classes run on the following days and times:

- Monday 12:30pm and 1:45pm
- Wednesday 12:30pm and 1:45pm
- Friday 12:30pm

You can discuss the best sessions to attend at your pre-assessment, with the program instructor. It can be a good idea to attend and view a class prior to booking in for your assessment.

Both your assessment and your classes are claimable with HBF and some other healthcare providers. Please notify us if you are planning to claim any of your expenses with your healthcare provider. Fees for the program are as follows:

- Assessment Fee - \$60.00
- Class Fee - \$10.00
- 10x Class Multi-Pass - \$100.00

Please read the attached forms. In order to get started in the program, you will need to complete the following:

- Book an initial 45-minute health and fitness assessment. Bookings can be made for Fridays at 1:45pm and 2:30pm. To book an assessment, please call the centre on 9385 8767.
- Consult your doctor and have them sign the attached 'Doctor Referral Letter'.
- Complete the 'Exercise & Training Readiness Assessment' and the 'Activities Specific Balance Confidence' forms.
- Attend your pre-booked initial assessment with one of the program instructors and bring your completed forms and Doctor Referral letter with you.

We look forward to getting you started in the Strength for Life program.

Kind Regards,

BOLD PARK AQUATIC

DOCTOR REFERRAL LETTER



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).

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Recent Surgery	<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Brain/Spinal Injury	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Neurological disorder	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Muscular pain	<input type="checkbox"/> Epilepsy/seizures
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Fall/Poor Balance	<input type="checkbox"/> Cancer	<input type="checkbox"/> 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 One** - classes provided by Exercise Physiologists and Physiotherapists
- Tier Two** - classes provided by Fitness Professionals who have completed the Strength for Life™ advanced training course.
- Working Seniors Tier** - for Seniors who need to attend outside standard working hours. Patient must be capable of participating in Tier Two environments without supervision.

REFERRING ORGANISATION OR CENTRE DETAILS

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



FOR CLARIFICATION CONTACT

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

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;

- | | |
|--|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Discomfort in the chest at rest or exertion | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma, emphysema, bronchitis - other lung problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Discomfort in the legs at rest or exertion | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Arthritis or major injuries in any joints | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Severe vein disorders in the legs, or feet, or ulcers | <input type="checkbox"/> Swollen feet/ankles |
| <input type="checkbox"/> Liver condition | <input type="checkbox"/> Glandular fever |
| <input type="checkbox"/> Kidney condition | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Dizziness/fainting |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Other (please specify) _____ | |

CARDIO-PULMONARY SYSTEM

1. Do you have, or have you experienced:

- | | | |
|-----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> 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 Vision or hearing
 Thermal (temperature control) Speech/ language
 Motor sensory

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

6. Do you have, or do you experience:

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

7. In the previous 12 months have you experienced:

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

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:

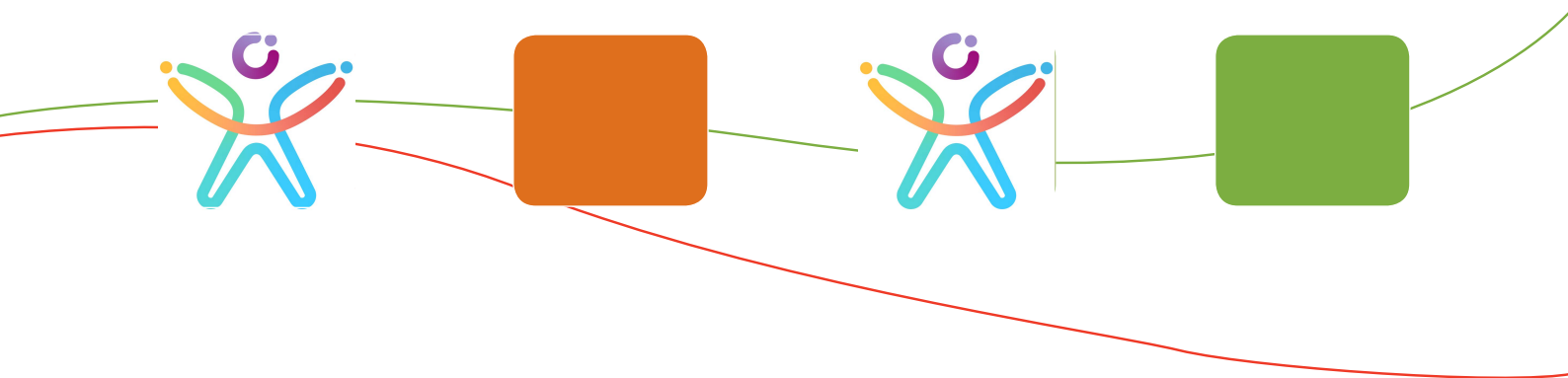
NAME OF MEDICATION/DRUG	FREQUENCY OF USE		
	Daily	Weekly	Monthly
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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:** _____



ACTIVITIES-SPECIFIC BALANCE CONFIDENCE

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. Stand on a chair and reach for something?

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

