Living Longer Living Stronger

- Assessment Pack -

We are delighted to hear you are interested in becoming involved with our Living Longer Living Stronger programme which promotes a healthy active lifestyle.

The initial assessment for the class costs $60, it takes 45minutes. They are run Fridays between 1:45pm and 3:15pm. The first Friday of each month assessments are not run as participants and the instructor go for coffee. Assessments are highly demanded, we apologise for the waitlists which may occur. To book an assessment please call the centre on 9385 8767, and bring this pack completed by yourself with you.
You must complete all documents with a yellow circle in the bottom right corner, and the Doctors Referral section must be signed by your doctor. This must be complete prior to the assessment.

Classes are run in a group environment using a variety of equipment. They are run in our Multipurpose room and cost $10. They are run on the following days;

- Mondays 12:30pm
- Mondays 1:45pm
- Wednesday 12:30pm
- Wednesday 1:45pm
- Friday 12:30pm

The sessions you are able to attend will be determined at your assessment. We do suggest you attending to view a class prior to booking in for an 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.

We look forward to seeing you at the centre.

Many thanks,

BOLD PARK AQUATIC CENTRE
215 THE BOULEVARD, CITY BEACH
9385 8767

DOCTOR REFERRAL LETTER

IMPORTANT GUIDANCE FOR COMPLETING REFERRAL

1. If your patient/client has chronic condition/s, injury rehabilitation needs or four or more risk factors please refer them to a Tier One Provider by completing the referral type check box overleaf.
2. If your patient/client has three or less low level risk factors please refer them to a Tier Two Provider by completing the referral type check box overleaf.

ELIGIBILITY FOR REFERRAL

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

TYPES OF PROVIDERS:

Tier One - Exercise physiologists and physiotherapists
Tier Two - Fitness professionals who have completed the Living Longer Living Stronger™ advanced training course.

Dear **Living Longer Living Stronger Program™ Co-ordinator**,

I am recommending my patient/client undertake a monitored Living Longer Living Stronger™ strength training program that incorporates a progressive resistance format.

PARTICIPANT DETAILS

Title (Miss, Ms, Mrs, Mr): ______________ Name: ______________________________

Address: ____

Suburb: ______________________ Postcode: __________ Phone: ______________________

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 Living Longer Living Stronger™ program.

Please consider the following when prescribing a training program:

1. ____

2. ____

3. ____

4. ____

5. ____

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 Living Longer Living Stronger™ advanced training course.

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: ____________________

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
llls@cotawa.org.au

PARTICIPANT TO COMPLETE, INSTRUCTOR TO REVIEW

EXERCISE & TRAINING READINESS ASSESSMENT

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 Living Longer Living Stronger™ program? (please tick one box below)

☐ 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

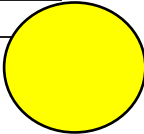
3. Do you take any medications for (please specify name):

☐ 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
- ☐ 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: ______________________________

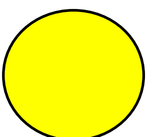
16. Do you have any allergies which may affect your capacity/ ability to exercise? ☐ Yes ☐ No

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:

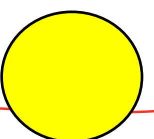
NAME OF MEDICATION/DRUG	FREQUENCY OF USE Daily	Weekly	Monthly
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Living Longer Living Stronger ™ (LLLS) Participants must read the following statements car efully and sign below understanding that ;

- I understand that the LLLS™ 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 LLLS™.
- I agree to follow the directions of my LLLS™ Instructor in my LLLS™ exercise program and will exercise at my own pace.
- I authorise the LLLS™ instructor and my GP to communicate about my progress in LLLS™ 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 LLLS™ forms can be accessed by the LLLS™ 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 (LLLS ™ Participant): ______________________________ **Date:** ______________



PARTICIPANT TO COMPLETE, INSTRUCTOR TO REVIEW

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. 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

PROVIDER TO COMPLETE

PHYSICAL MEASUREMENTS: INITIAL ASSESSMENT

NAME	
DOB	
BLOOD PRESSURE	
RESTING PULSE	
WEIGHT	
GIRTH MEASUREMENTS;	
RIGHT ARM	
LEFT ARM	
CHEST	
WAIST	
HIP	
Upper thigh (right)	
Upper thigh (left)	
Calf (right)	
Calf (left)	
WAIST TO HIP RATIO	
BALANCE TEST Level 1-6	

STARTING WEIGHTS (10 RM)	Leg Press (kgs)	Bench Press (kgs)	Seated Row (kgs)
Chair Rise to Stand (x5):			

DATE: ______________

WEEK NO. ___________

TEST NO. INITIAL

IMPORTANT, PLEASE NOTE: A Living Longer Living Stronger™ physical measurements reassessment is to be completed every 12 weeks from initial assessment.

PROVIDER TO COMPLETE

PHYSICAL MEASUREMENTS: REASSESSMENT

Full physical assessment must be completed every six months (24 weeks)
Updates should be made every three months (12 weeks)

NAME			
BLOOD PRESSURE			
RESTING PULSE			
WEIGHT			
WAIST TO HIP RATIO			
BALANCE TEST Level 1-6			
STARTING WEIGHTS	Leg Press (kgs)	Bench Press (kgs)	Seated Row (kgs)
Chair Rise to Stand:			

DATE: ______________

WEEK NO. ______________

TEST NO. ______________

1. Any change in health?

☐ Yes (please specify) ______________________________

☐ No (move to next question)

2. Any change or additional medications being taken?

☐ Yes (please specify) ______________________________

☐ No (move to next question)

Changes made to individualised exercise program:

Changes noticed by instructor:

IMPORTANT, PLEASE NOTE: A Living Longer Living Stronger™ physical measurements reassessment is to be completed every 12 weeks from initial assessment.