

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.

CLASS SCHEDULE

MONDAY

12:30 pm 1:45 pm

WEDNESDAY

12:30 pm 1:45 pm

FRIDAY

12:30 pm **1:45 pm NEW**

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.

PROGRAM FEES

\$75.00
Initial Assessment

\$15.00
Per Class

\$150.00
10 x Class Multi-Pass

Private health rebates available. Both your assessment and classes are claimable with HBF and some other healthcare providers. Please notify us when booking if you plan to claim with your provider.

HOW TO GET STARTED

- 1 Get a Doctor Referral**
Consult your GP and have them sign the enclosed Doctor Referral Letter. Bold Park Aquatic is a **Tier 2** Strength for Life provider.
- 2 Book Your Assessment**
Call us on [9385 8767](tel:93858767) to book your initial 45-minute health and fitness assessment. Assessment times are:
Wednesday 11:45am **Friday 3:00pm** **Friday 4:00pm**
- 3 Complete the Required Forms**
Fill out the *Exercise & Training Readiness Assessment* and the *Activities Specific Balance Confidence* forms included in this pack.
- 4 Attend Your Assessment**
Bring your completed forms and Doctor Referral letter to your pre-booked initial assessment with one of our program instructors. The forms should be handed straight to instructors.

We look forward to welcoming you to the program.

Bold Park Aquatic – Strength for Life Team

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).

<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:

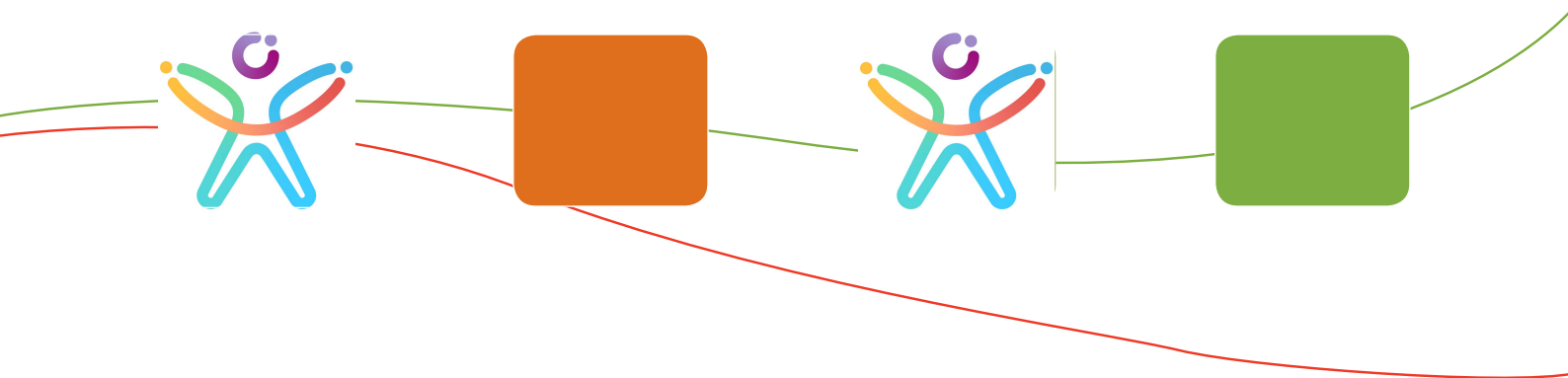
NAME OF MEDICATION/DRUG	FREQUENCY OF USE		
	Daily	Weekly	Monthly
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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





INFORMATION FORM

Strength For Life 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 and/or Torres Strait Islander person: Yes No

Concession Card: Yes No

Do you have a disability? Yes No

How did you find out about the program?

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____

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 Strength for Life™ 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 Strength for Life™ physical measurements reassessment is to be completed every 12 weeks from initial assessment.



The Town of Cambridge via the Bold Park Aquatic Centre collects this information in order to:

- Assess participant suitability for certain fitness programs and activities
- Develop safe and effective training plans tailored to individual needs
- Respond effectively in the event of an emergency
- Ensure that we are aware of any medical conditions that may impact participants of physical exercise
- Fulfill the requirements of Council on the Ageing (COTA) as registered providers of the Strength For Life program

We may share this information with:

COTA WA as required under the Strength for Life licensing agreement

Instructors and trainers involved in the Strength For Life program

Emergency services if required in the event of an emergency

Town of Cambridge staff responsible for administration, compliance or incident review

We must collect this information as our obligation the Council on The Ageing

COTA WA Strength for Life License Requirements – mandatory collection of health and screening data, Functional Assessments and GP clearances

If you choose not to provide personal information relating to you:

We may be unable to complete the required COTA WA Pre-Exercise Screening Tool

You may not be eligible to participate in the Strength for Life program

We may not be able to ensure your safety while exercising

If you have any questions about how your personal information will be handled or would like to gain access to your personal information, you can contact Bold Park Aquatic Centre on (08) 9385 8767 or bpac@cambridge.wa.gov.au.