­­**Lincoln City Foundation**

**Fighting Fit Referral Form**

First Name

Date of Birth

Email

Address

NHS Number (*if known*) …………………………………………….

PAM Score (Patient Activation Measure- *if known)* …………………………………….

Which session location are you interested in?

Lincoln (daytime) ☐ Lincoln (evening) ☐

Gainsborough ☐ Mablethorpe ☐ Boston ☐ Bourne ☐

……………………………………

……….........................................

....................................................

Last Name

Gender

Telephone

……………………………………

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………………………………………………………………………………………………………………….

**Referral Details**

Self-Referral ☐

Health Care Professional ☐

**Primary Reason for Referral?**

…………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………….

Name of referrer …………………………………………………………………………………………………………….........................

**Contact Details**

Name …………………………………………………………… Location …………………………………………………………………....

Telephone number ……………………………………………..Email ………………..……………………………………………………...

**Medical History**

**Cancer Diagnosis**

…………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………….

**Cancer Treatment**

Chemotherapy ☐ Radiotherapy ☐ Targeted Therapy ☐

Hormonal Therapy ☐ Surgery ☐

**Please list your side effects**

Osteoporosis ☐ Lymphoedema ☐ Cardiotoxicity ☐

Fatigue ☐ Limited Range of Movement ☐ Depression or Anxiety ☐

A picture containing icon

Description automatically generated**Do you have any physical limitations?**

…………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………….

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**Do you have any future cancer treatments planned?**

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**Do you have any other medical conditions we should be aware of?**

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Equal Opportunities

**Ethnicity**

☐ White

☐ Asian

☐ Black

☐ African

☐ Caribbean

☐ Black British

☐ Mixed or Multiple

☐ Other

**Emergency Contact Details (ICE)**

Name: ……………………………………………………………………………………………………………………………………………

Relationship to you:………………..……………………………………………………………………………………………………………

Contact:…………………………………………………………………………………………………………………………………………..

Research Participation

Bishop Grosseteste University are completing a research project exploring the perceptions of physical activity of those post cancer diagnosis (those who have had a diagnosis in the past 12 months). Participation in this study will involve taking part in a one-to-one interview, whereby the researcher will ask some questions about your thoughts and feelings on the exercise guidance you received following your diagnosis of cancer. The interview is completely voluntary, and you are free to refrain from answering any questions you feel uncomfortable answering or do not wish to disclose. The interview will take place in a quiet, private room at Bishop Grosseteste University and will be recorded to allow to transcription to occur.

☐ Please tick here if you would like to participate in this research study and consent to sharing your contact details with researchers at Bishop Grosseteste University

**Consent**

☐ Self-Referral Declaration (pre and during treatment) - If I am receiving, or about to receive any of the following treatments: chemotherapy, radiotherapy, targeted therapy, hormonal therapy, or surgery – I will consult with my clinical specialist nurse specialist prior to starting the physical activity programme. Should there be something that affects my ability to exercise, or I have a change in medication, I will inform the instructor immediately and stop exercising if necessary.

☐ Data Protection - We keep your records confidentially and securely. We will be required to share necessary information with delivery partners to ensure our duty of care to participants. Please tick this box to declare you acknowledge this.

☐ Data Protection - We keep your records confidentially and securely. From time to time, our partners ask for information for monitoring and evaluation purposes to help us improve our service. Please tick this box if you consent to this.

☐ Filming and Photos - I understand that from time to time, photographs or filming will be taken during the Fighting Fit sessions. All such photography and filming will be carried out by a Lincoln City Foundation approved person and used to promote the Fighting Fit programme. Please tick this box if you consent to this.

Please email to [Health@lincolncityfoundation.co.uk](mailto:Health@lincolncityfoundation.co.uk)