

PRIVATE Exercise Programme Referral Form



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PLEASE e-mail REFERRAL FORM TO clinic@orakinetics.co.nz

Patient's name: _____	DOB: _____
Address: _____ _____	
Phone: Home: _____	Work: _____
E-mail: _____	NHI no: _____
Ethnicity: _____	

If you want to refer a patient with a health condition outside the DHB's referral criteria for funded supervised exercise training at OraKinetics, then you can use this form. Below is a list of types of conditions which are not currently funded for clinical exercise physiology exercise reconditioning training by the DHB. At OraKinetics Clinic we will accept these referrals as private paying clients.

These can include but are not limited to patients with any of the following:

- Preventative care cardiovascular conditions (example; lipid and lipoprotein disorders, hypertension, low levels of fitness, general fatigue, and tiredness);
- Neuromuscular and skeletal conditions (example: Arthritis, Osteoporosis, Chronic Pain, Stroke, Multiple Sclerosis, and Parkinson disease);
- Metabolic disease and disorders (example: Obesity, metabolic syndrome, pre-diabetes and renal dysfunction);
- Recurrent musculoskeletal injuries/problems (example: back, neck, shoulder pain due to previous injury/muscle weakness/overuse);
- Pre- and post-surgery (example: hip and knee replacement patients);
- Pulmonary disorders (example; Early stage COPD, exercise-induced asthma);
- Elderly clients who could benefit from supervised exercise;
- Immunological Disorders (example; Cancer, CFS, and Fibromyalgia);
- Mental Health (example: depression, psychological burnout, anxiety).

Note: Some clients might be eligible for funding through WINZ and or private insurance companies. It is up to the client to investigate and apply for such funding (we will provide additional letters of support if required).

Please provide a brief description of your client relating to the aspects below. If deemed necessary, please add additional medical records (if available) to this referral.

Condition:

Medication:

Any Other information:

Signature

Date

Name (Please print or stamp)

Phone