­­

**Lincoln City Foundation**

**Fighting Fit Referral Form**

First Name

Date of Birth

Email

Address

Which session location are you interested in?

Lincoln ☐ Gainsborough ☐

Mablethorpe ☐

……………………………………

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

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

Last Name

Gender

Telephone

……………………………………

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

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

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

**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?**

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

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

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

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

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

Equal Opportunities

**Ethnicity**

☐ White

☐ Asian

☐ Black

☐ African

☐ Caribbean

☐ Black British

☐ Mixed or Multiple

☐ Other

**Emergency Contact Details (ICE)**

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

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

Contact:………………………………………………………………………………………………………

**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 & 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)