

1. Please fill in Sections 1, 2 & 3 of this self-referral form.
2. Contact Harbour Sport if you have any questions on 09 415 4657
3. Fax completed referral to 09 415 4594, email to [grx@harboursport.co.nz](mailto:grx@harboursport.co.nz) or post to Harbour Sport PO Box 300-633 Albany.

**Section 1 – Patient Details**

Your name: \_\_\_\_\_ Gender:  Male  Female Date of Birth: \_\_\_\_\_  
Ethnicity \_\_\_\_\_  
Street Address: \_\_\_\_\_ Suburb: \_\_\_\_\_  
Postcode: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

**Section 2 – Medical Conditions.** Tick the ones that relate to you.

- Respiratory conditions  Depression/Anxiety  CVD  High Cholesterol  Heart Conditions  Stroke  Stress  
 High Blood Pressure  Weight Loss Support  Arthritis  Injury  Mental Health Conditions  Epilepsy  
 Joint replacement  Osteoporosis  
 **Smoker:** I smoke \_\_\_\_\_ cigarettes per day

**Diabetes**

- Pre-diabetic (HbA1c 41-49mmol)  Gestational Diabetes  Type 2  Type 1  
 Have you attended a DSME course? (Diabetes Self-Management Education course)

**Any other relevant medical information?** \_\_\_\_\_

**Current Physical Activity**

- How many days a week are you active for 30 minutes or more in total? \_\_\_\_\_  
- What level of intensity is your activity?(circle one) Low Medium High

- Are you interested in our Green Prescription programmes? If so tick the box(es) Stanmore Bay  Glenfield/Birkenhead   
WestWave  Albany

**Section 3 – Medical Centre information**

Your Medical Practice: \_\_\_\_\_

Your Doctor/Nurses name: \_\_\_\_\_

Your signature: \_\_\_\_\_ Today's date: \_\_\_\_\_

**(By signing this form it indicates that you are interested in participating in the Green Prescription programme)**

**Section 4 – For Medical Centre Use Only.**

Name of Doctor/Nurse: \_\_\_\_\_

Dr/Nurse's signature: \_\_\_\_\_

**(By signing my name above, I give consent for my patient to safely start a Green Prescription exercise programme)**