

**REAP SCOTLAND
THERAPEUTIC GARDENING REFRRAL FORM**

Return completed form to: Alasdair Taylor, Grow Elgin Project Manager, REAP Scotland
info@reapscotland.org.uk or post to REAP, 177 Mid St. Keith, AB55 5BL

Personal details

Name _____

Male / Female / Transgender / Other _____

Address _____

Tel no. _____ D.O.B. _____

Next of kin _____

Relationship _____ Tel no. _____

Exercise readiness

1. Has a doctor recently indicated that you should restrict your physical activity?
Yes* No

2. Do you have high blood pressure that is *not* being treated and/or monitored?
Yes* No

3. Do you have a heart condition that is *not* being treated and/or monitored?
Yes* No

**If you answered 'yes' to any of the above questions, please provide a letter from your GP/RMO outlining your suitability to take part in a REAP Therapeutic Gardening Session.*

Medication

4. Please give details of any medication you take which may affect exercise or first aid situations:

Mental health

5. What mental health issue(s) do you have?

Physical health

6. Do you have any physical limitations that would make physical activity difficult?

Back pain	<input type="checkbox"/>	Obesity	<input type="checkbox"/>
Amputation	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>
Injury	<input type="checkbox"/>	Rheumatic arthritis	<input type="checkbox"/>
PVD	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	Other joint pain	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>
Functional post stroke	<input type="checkbox"/>	Other	<input type="checkbox"/>

Please give details _____

7. Please give details of any breathing problems or allergies

8. If you have epilepsy, how often do you have a seizure?
Daily Weekly Monthly Rarely

9. If you are diabetic, which type do you have?
Insulin-dependent Non-insulin dependant

10. Please give details of any learning difficulties

11. Are you pregnant?
Yes No

I wish to join the REAP Therapeutic Gardening programme, and know of no reason why I cannot take part.

Client's signature _____

Referring Service Details

I wish to refer this participant to REAP Therapeutic Gardening Programme, and know of no reason why he/she cannot take part

Name _____ Job title _____

Referring service _____ Date __ / __ / __

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