HEALTHY CONNECTIONS

STARTERS PACK

60 Kuran Street, Chermside

07 3624 2185
gym@healthyconnections.org.au

Monday - Friday
6am - 12pm & 3pm - 6pm
(Thursday closed 5pm)

Saturday | 6am - 10am

WELCOME

Congratulations on joining Healthy Connections Exercise Clinic, our clinic is an extension of the health and fitness activities which have been offered at Burnie Brae for over 30 years. We are delighted to provide a facility where not only seniors, but anyone over the age of 18, can exercise and improve their health in a secure, supported and friendly environment under the supervision of accredited exercise physiologists.

Exercise is important for people of all ages. Healthy Connections we ensure that an exercise program is suitable for you as an individual. Before clients commence their program with us, they must complete the following checklist.

- ☐ Completed 'Personal Details' (pg 3)
- ☐ Completed your 'General Practitioner Details' (pg 3)
- ☐ Read & completed 'Pre-participation Screening Questionnaire' (pg 4)
- ☐ Read & understood 'Preparation For Initial Assessment Checklist' (pg 4)
- ☐ GP has completed & signed 'GP Medical Practitioner' form (pg 5-6).
  Step only required if requested by Healthy Connections Clinic.
- ☐ Completed & signed 'Medical History Questionnaire' (pages 7-9)
- ☐ Read & signed 'Terms & Conditions, Participant Consent Form' (pg 10 - 12)
- ☐ Read & understood pricing and clinical passes (pg 13)
- ☐ Read & understood 'Clinic Etiquette' (pg 14)

We hope you enjoy being part of Healthy Connections Exercise Clinic and look forward to working with you to increase your health, fitness and well being.

Yours sincerely,

Karen Stewart-Smith MCEP BHMS
Accredited Exercise Physiologist
Manager – Healthy Connections Exercise Clinics

PERSONAL DETAILS

Title: First Name:

Family Name:

Gender: Female ☐ Male ☐ Other ☐ Date of Birth: / /

Address:

Postcode:

Phone (Home): (Mobile): (Work):

Email: Occupation:

Emergency Contact 1: Contact Number:

Emergency Contact 2: Contact Number:

GENERAL PRACTITIONER DETAILS

Name: Practice:

Phone: Fax:

Address:

Postcode:

Do you consent for us to contact the above practitioner to obtain clinically relevant information and/or send a report on your treatment plan if required? Y ☐ N ☐

Public/Private Health Details:

Medicare No: Patient IRN: Exp Date:

Private Health Fund: Membership No:

Concession card: Yes ☐ No ☐ Type:

DVA File No: Card Type: GOLD ☐ WHITE ☐

Do you identify as Aboriginal or Torres Strait Islander: Yes ☐ No ☐

Pre-participation Screening Questionnaire

Please tick

Y	N	
☐	☐	Has your doctor informed you that you have a heart condition or have you ever suffered a stroke?
☐	☐	Do you feel faint or have dizzy spells during physical activity/exercise that causes you to lose balance?
☐	☐	Have you suffered an asthma attack requiring immediate medical attention/hospitalisation in the last 12 months?
☐	☐	If you have diabetes (type I or II), have you had trouble controlling your blood glucose in the last 3 months?
☐	☐	Do you have any diagnosed muscle, bone or joint problems that you've been advised could worsen by participating in physical activity/exercise?
☐	☐	Do you have any other medical condition(s) that make it dangerous for you to participate in physical activity/exercise?

If you answered YES to any questions, please consult your doctor and request their signature on PAGE 6 prior to attending your initial assessment.

PREPARATION for Initial Assessment

ITEMS

Comfortable clothes, enclosed footwear, water bottle, towel and completed forms.

MEDICATION

Continue regular medication schedule. Persons with diabetes, pulmonary/cardiac complications are to bring any necessary medications to the assessment (e.g. insulin/inhaler)

FLUIDS & FOOD

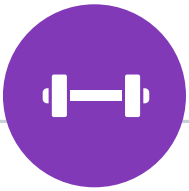
Drink plenty of water up to 24 hours prior to assessment.

Consume water and other non-milk fluids as normal.

No large meal within 3 hours and no food within one hour of assessment.

STIMULANTS

No smoking, alcohol or caffeine within 3hrs of testing.



EXERCISE/TRAINING

No intense training the day before, or morning of testing.

GP MEDICAL

PRACTITIONER FORM

Healthy Connections Exercise Clinic

The exercise clinic provides clinical exercise interventions for a broad range of conditions including chronic diseases, musculoskeletal pathologies, cardiac rehabilitation, disabilities and also for general healthy populations. Every participant is prescribed a program, based upon the results of a comprehensive health and fitness assessment and previous medical history.

We offer group and individual programs fully supervised by accredited exercise physiologists, committed to educating and empowering every client to understand and self-manage their own health conditions.

Client Request

By completing this form, your patient has started the process to better health with us and would like to participate in regular, supervised exercise sessions. These sessions will be either general exercise physiology group sessions or other specialised clinical programs including cardiac rehabilitation sessions. Whilst most individuals will be suitable to exercise, the GP Medical Information Form allows contraindications to exercise, to be assessed, ensuring that the clinical exercise prescription is the most accurate and safe it can be. Please complete page 4, 5, 6 and sign page 6. With your patients consent, it would be appreciated if you could attach a patient medical summary.

Medical Practitioner Details

Name Practice

Address Postcode

Phone Fax

Participant Details

Miss / Ms / Mrs / Mr / Other (please circle) Date of Birth

First Name Surname

CONTRAINDICATIONS

to Exercise Participation

Absolute Contraindications

(tick if applicable)

- ☐ Unstable angina
- ☐ Uncontrolled hypertension – that is resting systolic blood pressure (SBP) >180mmHg and/or resting diastolic BP (DBP) >110mmHg.
- ☐ Orthostatic BP drop of >20mmHg with symptoms
- ☐ Significant aortic stenosis (aortic valve area <1.0cm2)
- ☐ Uncontrolled atrial or ventricular arrhythmias
- ☐ Uncompensated heart failure
- ☐ Third-degree atrioventricular block (AV) without pacemaker
- ☐ Active pericarditis or myocarditis
- ☐ Recent embolism
- ☐ Acute thrombophlebitis
- ☐ Acute systematic illness or fever
- ☐ Uncontrolled diabetes mellitus
- ☐ Severe orthopaedic conditions that would prohibit exercise
- ☐ Other metabolic conditions, such as acute thyroiditis, hypokalaemia, hyperkalaemia, or hypovolemia (until adequately treated)

Relative Contraindications

(tick if applicable)

- ☐ Fasting blood glucose >16.7mmol/L
- ☐ Uncontrolled hypertension with resting systolic blood pressure >160mmHg or diastolic blood pressure >100mmHg
- ☐ Severe autonomic neuropathy with exertional hypotension
- ☐ Moderate stenotic valvular heart disease
- ☐ Tachyarrhythmias or bradyarrhythmias
- ☐ Neuromuscular, musculoskeletal or rheumatoid disorders that are exacerbated by exercise
- ☐ Microvascular complications (retinopathy, neuropathy, nephropathy)
- ☐ Macrovascular complications (cerebrovascular, CVD, PVD)

Please list any other diagnosed medical conditions or recommendations:

As the supervising doctor, I found the individual to be medically stable at the time of this examination and therefore approve their participation in an exercise program. I have indicated relevant contraindications to my knowledge and understand that should the participant experience a medical incident during participating, I will be informed immediately.

☐ *I have attached a copy of the patient's medical summary to this form.*

Medical Practitioner's signature: _____ Date:

Form Completion Date

MEDICAL HISTORY QUESTIONNAIRE

Miss / Ms / Mrs / Mr / Other (please circle) Date of Birth

First Name Surname

Do you have any family history of heart disease, lung disease or cancer?

Relative	Age	Condition

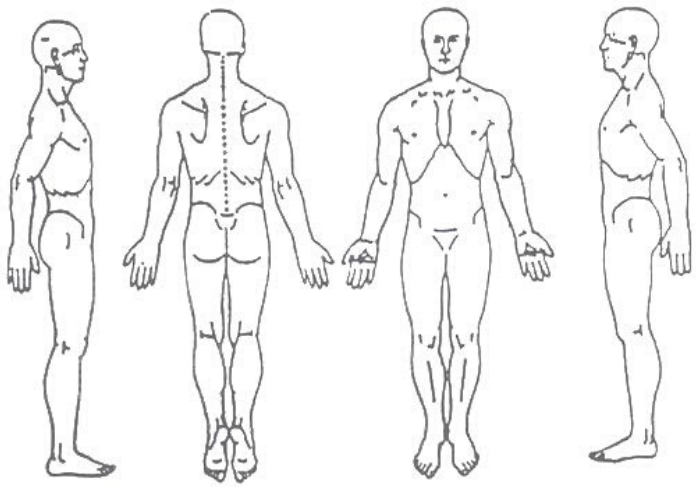
	Y	N		
Are you or have you been a smoker?	☐	☐	Age you started smoking	
Average no. cigarettes smoked per day			Age you quit smoking	

Please tick

Y	N	Cardiovascular	Diagnosis Date / Comments
☐	☐	Angina (chest pain)	
☐	☐	Heart disease	
☐	☐	Heart attack (MI)	
☐	☐	Heart failure	
☐	☐	High blood pressure/Hypertension	
☐	☐	Low blood pressure/Hypotension	
☐	☐	High cholesterol	
☐	☐	Stroke	
☐	☐	Arrhythmia	
☐	☐	Pacemaker or ICD	
☐	☐	Valvular disease (heart)	
☐	☐	Valvular disease (blood vessels)	
☐	☐	Heart surgery	
☐	☐	Other	
		Respiratory	
☐	☐	Asthma	
☐	☐	COPD	
☐	☐	Bronchitis	
☐	☐	Emphysema	
☐	☐	Pneumonia	
☐	☐	Other	

Please tick

Y	N	Metabolic & Endocrine	Diagnosis Date / Comments
☐	☐	Type II Diabetes	
☐	☐	Gestational diabetes	
☐	☐	Kidney disease	
☐	☐	Thyroid disorder	
☐	☐	Cancer Type:	
☐	☐	Colon problems (IBD, diverticulitis)	
☐	☐	Other	
		Neurological & Psychological	
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Epilepsy	
☐	☐	Multiple Sclerosis	
☐	☐	Parkinson's Disease	
☐	☐	Cerebral Palsy	
☐	☐	Intellectual impairment	
		Do you experience sudden tingling, numbness or loss of feeling in your arms, hands, legs or face?	
☐	☐	Other	
		Musculoskeletal	
☐	☐	Osteoarthritis	
☐	☐	Rheumatoid arthritis	
☐	☐	Rheumatic disease (Fibromyalgia, lupus)	
☐	☐	Osteoporosis/osteopenia Recent DXA scan date:	
☐	☐	Menopause Age when it started:	
☐	☐	Broken bones	
☐	☐	Other	



Please circle to indicate the areas you currently experience pain.

Have you had any other surgeries, significant injuries or hospitalisations?

Please list your current medications:

Medication	Time Taken am / pm	Dose

Other	Y	N	AHP
Are you currently seeing any other allied health professionals?	☐	☐	
Please circle:			
Physiotherapist, Occupational Therapist, Dietician, Diabetes Educator, Podiatrist, Psychologist/Psychiatrist.			
If other please list			

Participant signature: _____ Date: _____

Practitioner Use Only

Risk Stratification	LOW	MOD	HIGH
Cardiovascular Risk Statification	LOW	MOD	HIGH
GP Consent Requested Yes ☐ No ☐	Date:		

Terms & Conditions

Please read the following terms, conditions and personal consent carefully. Your signature acknowledges your understanding and willingness to abide by the contents enclosed. Please request assistance if you are unsure before signing. You must complete all required documentation and agree to follow directions of Healthy Connections staff in their recommendation of an appropriate program for your individual needs.

The information set out in this agreement overrides any statements made by you or us before you signed the agreement. Accordingly, you should read through the document carefully to ensure it reflects your expectations and seek advice if you are unsure of any particular statements. Information you provide will be true and accurate and not misleading in any way.

Healthy Connections may adjust the agreement including (but not exclusive to) our pricing, policy and etiquette. Members will be notified in writing of these changes with at least 30 days notice, unless it is impractical for us to do so. An opportunity to cancel your membership without incurring a cancellation fee is available if you do not agree to, or are adversely affected by the change/s, as long as we are informed in writing prior to the change coming into effect. Please note a cancellation fee will apply under this clause if we are required to make the changes in order to comply with a law or any direction of a competent authority.

Healthy Connections reserves the right to terminate membership agreements for failure to follow directions, misconduct, inappropriate behaviour and bullying of other members or staff. Members are entitled to terminate the agreement at any time. In this instance, membership fees will be reimbursed less $15 per session already attended plus a $75 administration fee.

USING THE EXERCISE CLINIC

Prior to commencement at Healthy Connections a full assessment is compulsory and you must provide a signed GP Medical Consent and completed Medical History Questionnaire.

Exercise clinic members agree to inform Healthy Connections staff of any change in their health status (not already stated on the Medical & Health History Questionnaire) which may increase their risk of illness or injury through participation in an exercise program.

Members must not attend and use the facilities and services whilst suffering from any illness, disease, injury or other condition that could present a risk to the health and safety of other members, students, staff or themselves. Members agree to stop exercising and inform Healthy Connections staff if they experience any change or decline in health condition. If an attending staff member identifies a medical emergency due to a client's physical or psychological state, they must contact emergency services.

By signing this agreement you agree to abide by the rules outlined in our clinic etiquette (on back page & also displayed in the clinic) whilst at Healthy Connections.

PRIVACY

Healthy Connections respects and upholds your right to privacy and will ensure your personal information is maintained as per the requirements stipulated under the Australian Privacy Principles and Privacy Amendment Enhancing Privacy Protection Act 2012.

At Healthy Connections your records are secure and safe and we only collect information that is relevant to the service/s provided and with your acknowledgement. You have the right to access your records and request amendments to any incorrect information held. We seek informed consent from you to collect and share your information with certain people and/or organisations in order to provide the best possible service.

OPENING HOURS & SESSION BOOKINGS

Healthy Connections is closed for all public holidays (and additional days between Christmas and New Year). Membership prices are inclusive of these closures. Booking exercise sessions is essential and participants must notify the Healthy Connections reception if they are unable to attend a session. Failure to advise of non-attendance may result in that session being charged.

Failure of a member to attend their booked time slot for three consecutive sessions, without notice, will see their allocation to that time slot cancelled. Changes to booked session times can be accommodated provided the new session time is available, and the changes have been agreed with exercise clinic staff prior to commencement.

MEMBERSHIP CONDITIONS

Memberships may be transferred to another party. Original use and expiry dates will apply. The original member must notify Healthy Connections in writing to inform whom the membership is being transferred and their contact details. This person will be required to undergo a full assessment (costs apply).

Members holding a 3 or 6 monthly membership can defer their membership, twice during the membership period to accommodate for holidays and extended periods of sickness. 3 monthly memberships may be deferred for no less than one week, and up to a total of 4 weeks. 6 monthly memberships may be deferred for no less than one week and up to a total of 6 weeks. Deferment of less than 1 week is not accepted. Once the deferment period has been used, the membership period will continue to expire. Requests for membership deferment are required in writing to the clinic or emailed to gym@healthyconnections.org.au, prior to the deferment period starting.

RESEARCH

Healthy Connections is a facility that believes in teaching the next generation of skilled clinicians. Students observing or participating in consultations have signed and are bound by strict confidentiality agreement. If your record is used as a teaching aid, identifying information will be removed before use. Students will only engage in work within their scope of practice and level of competence.

Any research conducted within this facility will have ethics approval and be conducted in accordance with the National Statement on Ethical Conduct in Human Research. Research activities conducted at the clinic may access your medical records to assess your suitability for a project. Your participation in this research is optional and will not affect your routine clinical care.

I do / do not authorise Healthy Connections to use my exercise results for data analysis and research purposes.

OBTAINING & EXCHANGING PERSONAL INFORMATION

I have been informed and understand how this information will be used, and that this information will not be passed on to other parties except as outlined above. I understand that I can change my mind about the parties I want my Exercise Physiologist to talk to. If I change my mind, I will let my Exercise Physiologist know.

I understand that my participation in sessions at Healthy Connections imposes the risk of possible physical injury/ physical harm. I understand that I have the freedom to withdraw from any program, at any time and for any reason, without prejudice.

I do / do not authorise Healthy Connections to obtain & exchange information to the following parties: community organisations, other health professionals, associate funding Government bodies & other parties.

I do / do not consent to receiving Healthy Connections marketing materials or campaigns.

Personal Consent

I understand and agree to follow the prescribed exercise program that is delivered to me. I acknowledge that I am exercising at my own risk and take full responsibility for my actions.

I agree to indemnify Burnie Brae Ltd. & Healthy Connections Exercise Clinic as Principal from all actions, costs, claims, charges, expenses, penalties etc. arising from my participation in activities conducted and organised by Burnie Brae Ltd.

If any member is judged incapable to sign the terms and conditions form, prior consent must be sought from the client's parent/ legal guardian before the member is able to commence services with Healthy Connections. The parent or guardian who signs this form takes full responsibility for entering into the terms and conditions of this agreement.

A cooling off period of 48 hours applies from the date of signing this agreement. This does not include assessment costs incurred.

☐ I have read through this form including any attachments in full before signing

☐ By signing here I/we agree to be bound by the terms and conditions of this membership

Member name _____ Date _____

Signature: _____

Legal Guardian PRINT NAME _____ Relationship to Member _____

Signature: _____

Burnie Brae
MEMBERPLUS

$100

STARTER PACK*

Initial assessment | 45 min
Customised program
1:1 session | 45 min

Valid 13 weeks from purchase date.
T&C's available at
burniebrae.org.au/membership

INITIAL ASSESSMENT	
45 minutes	$125
RE-ASSESSMENT	
30 minutes	$45*

CLINICAL PASSES	
Casual	$37
10 sessions	$110*
3 month	$260*
6 month *Incl: 5 classes / week (fitness, zumba, yoga, fitball fitness & functional fitness)*	$480*

* **Discounts may apply.**

Prices may vary. Select services offer 10% off for concessions and some may be GST exempt.

Enquire for further details

- 10 sessions & 3 month clinical passes valid 13 weeks from purchase date.
- 6 month clinical pass valid 25 weeks from purchase date.

Deferment periods available (policy page 14).

HICAPS AVAILABLE

PRIVATE HEALTH REBATES
May apply, check with your provider.

DVA HEALTH CARDS
Gold & white accepted as payment upon GP referral.

CHRONIC DISEASE MANAGEMENT
Medicare Team Arrangements Care

NDIS APPROVED
Visit website or contact for details.

Pricing valid January 2020.

CLINIC ETIQUETTE

The following rules are non-negotiable and are a part of the documents supplied with the terms and conditions forms you sign prior to attending Healthy Connections clinics.

- Bring along a towel & water bottle
- Use the hand sanitiser provided
- Wipe down equipment after use & return it to its original location
- Show courtesy to other gym users If you're unwell, please don't train
- If your health situation changes you MUST inform us
- Shirt & enclosed shoes compulsory *(no work boots)*
- A Practitioner must be present for you to begin your exercise session
-
- Use one piece of equipment at a time
- Don't drop your weights *Particularly dumbbells and barbells*
- Follow directions of Healthy Connections staff
- Book your session times & advise if you cannot attend
- Talk to a Practitioner to update your program
- Gym is a camera free zone *Approval required prior to filming*
- Reassessment required if you're away over 3 months (charges apply)

ENTITLEMENTS

- Personalised exercise prescription
- Updated program every 13 weeks
- Supervised exercise sessions
- Access to experienced Accredited Exercise Physiologists for exercise guidance/advice
- Use of modern exercise equipment
- Reception staff available from 9am – 3pm on operational days