Reboot Your Life: Living Well with Arthritis Program

Please complete the sections below and return to Arthritis SA via email to reboot@arthritissa.org.au or post to 111a Welland Avenue, Welland SA 5007

Title:	First name:	Last name:
Address:		Suburb/Town:
State/Territory:	Postcode:	Date of Birth: _____ / _____ / _____
Phone (h):	Mobile:	
I prefer to be contacted via (please tick one): ☐Email ☐Phone		
Email address:		
Emergency contact name:		Emergency contact phone:

MEDICAL INFORMATION – please answer ALL questions

1. Has your medical practitioner ever told you that you have a heart condition, or have you ever suffered a stroke?
   ☐ YES ☐ NO
2. Do you ever experience unexplained pains or discomfort in your chest at rest or during physical activity/ exercise?
   ☐ YES ☐ NO
3. Do you ever feel faint, dizzy, or lose balance during physical activity/ exercise?
   ☐ YES ☐ NO
4. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?
   ☐ YES ☐ NO
5. If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the last 3 months?
   ☐ YES ☐ NO
6. Do you have any other conditions that may require special consideration for you to exercise? E.g., recent surgery or injury? ☐ YES ☐ NO

Please tick which type of arthritis you have and where it is in your body:

☐ Osteoarthritis ☐ Gout ☐Ankylosing spondylitis ☐ Fibromyalgia

☐ Rheumatoid arthritis ☐ Psoriatic arthritis ☐Other: _____

It affects my: ☐ Neck ☐ Back ☐ Shoulders ☐ Wrists ☐ Feet ☐ Fingers
☐ Hips ☐ Knees ☐ Ankles ☐ Other: _____

Do you have, or have you had any of the following?

☐ Broken bone(s) ☐ Osteoporosis/osteopenia ☐ Migraines/headache ☐ Stroke

☐ Sprain(s) ☐ Incontinence ☐ Dizziness ☐ Diabetes

☐ Dislocation(s) ☐ Anaemia ☐ Chronic fatigue ☐ Respiratory issues

☐ Asthma ☐ Cancer ☐ Depression/anxiety ☐ High or low blood pressure

☐ Heart disease/ chest pain/ heart condition

Surgery in the last ☐ 3 months ☐ 12 months ☐ 3 years Other: _____

Please provide more details on the above:

_____

_____

_____

Do you use any of the following to assist with your mobility?

☐ Wheelchair ☐ Walker ☐ Walking stick ☐ n/a

Can you get on and off the floor independently? ☐ YES ☐ NO

Have you had any falls in the past year?

☐ Yes ☐ No ☐ No, but I am worried about falling

If yes, how many? _____

Did you need to see your GP or go to the emergency department for treatment (e.g., X-ray, stitches)?

_____

Please note that a Medical Clearance may need to be signed by your GP depending on your health status. Arthritis SA will contact you if this is required before you start. *Note: Please be aware this Medical Clearance and Agreement Form is only valid for a period of 12 months from the date the form is signed by your doctor.*

Please provide your GPs details below so Arthritis SA can let them know you are doing this program and provide them with a copy of your assessment data to be added to your health record *(this is a condition of entry from the grant funder)*

GP name: _____

Name of clinic you attend: _____

Clinic phone number: _____

Participant Informed Consent and Disclaimer

I, _____

(Please Print Full Name)

hereby apply to participate in the Reboot Your Life: Living Well with Arthritis program. The program is run by Arthritis SA in association with it's professional Service Providers. The program has been made possible by funding from Country SA Primary Health Network (CSAPHN).

1. Purpose and Explanation of Participation Requirements

I hereby consent to voluntarily engage in the Reboot Your Life: Learn to Live Well with Arthritis program ('the program'). I understand that I will be asked to complete several assessment forms and undergo an exercise screening prior to and at the conclusion of my involvement in the program and a pre-program safety check (online program only). This screening is to track progress and change made during the program and to ensure safety. I understand that the program is grant funded and is free for the life of the grant. The program is delivered in fixed blocks. Access to Block one (10 weeks) is one off only. Access to Block 2 (continuing exercise program) is optional following completion of Block one if I am eligible*.

I will participate in all aspects of the program and all required sessions each week. I will be guided through an appropriate exercise program lead by qualified fitness and health professionals. I understand that I am expected to follow staff instructions about exercise to ensure safe participation and reduce risk of injury. If I am taking prescribed medication, I have already informed the program staff and further agree to inform them promptly of any changes which my doctor or I have made regarding the use of these.

I consent to participate in Arthritis SA's Reboot Your Life: Learn to Live Well with Arthritis program and acknowledge unconditionally that I have given an accurate account of my health, any relevant medical conditions, and my ability engage with and to safely participate in the program. I acknowledge that it is solely my responsibility to advise Arthritis SA and Service Providers of my medical status, health and/or physical ability to changes in a way that could reasonably be expected to affect, in any way, my safe participation in the program. If I am unsure as to whether a change in my medical status, health and/or physical ability will affect my safe participation in the program, it is my responsibility to consult a doctor or other appropriately qualified healthcare professional.

I have been informed that during my participation in the exercise portion of 'the program', I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar symptoms appear. At this point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the exercise program staff leading my class of my symptoms, should any develop.

**To be eligible for the continuing exercise program participants must have completed all 10-weeks of the Reboot Your Life: Living Well with Arthritis program including all assessments and surveys. Free continuing exercise classes will only then be offered to individuals for a period no longer than 6-months subject to their continued participation in re-assessment and survey completion at 3-month intervals.*

2. Risks

It is my understanding and I have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by proper staff assessments of my condition before each exercise session, staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as herein indicated.

I understand that it is my responsibility to ensure that I have a safe environment to complete 'the program' in including the exercise component while participating in this program. Every will be made by Arthritis SA and UniSA/ your Service Provider to advise me of safety procedures and potential hazards prior to starting the program.

3. Privacy Agreement

Arthritis SA collects information from you for the primary purpose of supporting you to access the Reboot Your Life: Living Well with Arthritis program. To enable ongoing support, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

☐ I give permission to be contacted by SMS to your mobile phone number and/or email to the address you have provided?

☐ I give permission for disclosure of health information to others involved in supporting you to participate in the program (your nominated GP, and Uni SA (telehealth group)/ Service Provider (in person groups)).

For the purposes of reporting, data such as program results and outcomes will be provided to the funding body. This data is deidentified and does not include individual details or individual program results.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important, and we will take all steps necessary to ensure they remain confidential.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

Signature: _____ Date: ____/ ____/____