Reboot Your Life: Living Well with Arthritis Program

This program is conducted entirely online. If you do not have access to the internet, you will be unable to participate. Please complete all the forms enclosed and return to Arthritis SA.

Title:	First name:	Last name:	
Address: Note: If you are completing exercise classes somewhere other than your home address listed, please provide that 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 you will use in this program:			
Emergency contact name:	Emergency contact phone:		

MEDICAL INFORMATION

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

☐ Osteoarthritis ☐ Gout ☐Ankylosing spondylitis

☐ Rheumatoid arthritis ☐ Psoriatic arthritis ☐Other _____

It affects my: ☐ Neck ☐ Back ☐ Shoulders ☐ Wrists

☐ Fingers ☐ Hips ☐ Knees ☐ Ankles

☐ Feet ☐ Other _____

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

Indoors

☐ Wheelchair ☐ Walker ☐ Walking stick ☐ n/a

Outdoors

☐ Wheelchair ☐ Walker ☐ Walking stick ☐ n/a

Have you had any falls in the past year?

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

Reboot Your Life: Living Well with Arthritis Program

Informed Consent and Disclaimer

I, _____ of

(Please Print Full Name)

_____

(Full address) & (Phone Number)

Hereby apply to participate in the Reboot Your Life: Living Well with Arthritis online program. The program is run by Arthritis SA in association with Uni SA and other professional Service Providers. This service has been made possible by funding from Country SA PHN (CSAPHN).

1. Purpose and Explanation of Participation

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. 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 with regard to 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 to advise me of safety procedures and potential hazards prior to starting the program.

3. Privacy

Arthritis SA collects information from you for the primary purpose of supporting you to access 'the 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 via my mobile phone number and/or email to the address I have provided.

☐ I give permission for disclosure of health information to others involved in supporting me to participate in this program (My nominated GP, and UniSA/ Service Provider for participation in the exercise component, referring healthcare professional if different from referring GP).

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: ____/ ____/____

Funded by phn COUNTRY SA An Australian Government Initiative

Arthritis SOUTH AUSTRALIA

UniSA Allied Health & Human Performance

ADULT PRE-EXERCISE SCREENING SYSTEM (APSS)

This screening tool is part of the Adult Pre-Exercise Screening System (APSS) that also includes guidelines (see User Guide) on how to use the information collected and to address the aims of each stage. No warranty of safety should result from its use. The screening system in no way guarantees against injury or death. No responsibility or liability whatsoever can be accepted by Exercise & Sport Science Australia, Fitness Australia, Sports Medicine Australia or Exercise is Medicine for any loss, damage, or injury that may arise from any person acting on any statement or information contained in this system.

Full Name: _____

Date of Birth: _____ Male: ☐ Female: ☐ Other: ☐

STAGE 1 (COMPULSORY)

AIM: To identify individuals with known disease, and/or signs or symptoms of disease, who may be at a higher risk of an adverse event due to exercise. An adverse event refers to an unexpected event that occurs as a consequence of an exercise session, resulting in ill health, physical harm or death to an individual.

This stage may be self-administered and self-evaluated by the client. Please complete the questions below and refer to the figures on page 2. Should you have any questions about the screening form please contact your exercise professional for clarification.

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

IF YOU ANSWERED 'YES' to any of the 6 questions, please seek guidance from an appropriate allied health professional or medical practitioner prior to undertaking exercise.

IF YOU ANSWERED 'NO' to all of the 6 questions, please proceed to question 7 and calculate your typical weighted physical activity/ exercise per week.

7. Describe your current physical activity/exercise levels in a typical week by stating the frequency and duration at the different intensities. For intensity guidelines consult figure 2.

Intensity	Light	Moderate	Vigorous/High
Frequency (number of sessions per week)			
Duration (total minutes per week)			

Weighted physical activity/exercise per week

Total minutes = (minutes of light + moderate) + (2 x minutes of vigorous/high)

TOTAL = _____ minutes per week

- If your total is less than 150 minutes per week then light to moderate intensity exercise is recommended. Increase your volume and intensity slowly.
- If your total is more than or equal to 150 minutes per week then continue with your current physical activity/exercise intensity levels.
- It is advised that you discuss any progression (volume, intensity, duration, modality) with an exercise professional to optimise your results.

I believe that to the best of my knowledge, all of the information I have supplied within this screening tool is correct.

Client signature: _____ Date: _____

Reboot Your Life: Learn to Live Well with Arthritis Program

Medical Clearance Form

Reboot Your Life is a 10-week online self-management program of education, mindfulness, and exercise for people over 50 (40+ First Nations descent) living in regional South Australia with arthritis and related MSK conditions.

Dear Doctor,

In signing this form, you believe that (Participant's name) _____ can safely participate in a telehealth-based or face-to-face exercise program.

Please complete this patient's Medical Status below and declare that the information you have given is accurate to the best of your knowledge as of the date below.

Does this patient have any of the following? (please tick appropriate & state nature of condition)

☐ Arthritis (Please list type)
☐ Abnormal blood pressure
☐ Respiratory conditions
☐ History of falls
☐ Joint replacements
☐ Osteopenia/ osteoporosis
☐ Mild stroke/Parkinson's disease/multiple sclerosis
☐ Cardiac problems
☐ Diabetes
☐ Epilepsy
☐ Kidney disease
☐ Recent surgery (past 12mths)
☐Other _____

If you agree that your patient can participate in the exercise program, are there any aspects of the patient's health that the program providers should be aware of?

_____

_____

Doctors' Name: _____ Signature: _____

Date: _____

Please be aware this Medical Clearance and Agreement Form is only valid until such a time as a change in medical circumstances occurs.

Return all forms to Arthritis SA 1800 011 041 via email health.services@arthritissa.org.au or via post 111a Welland Avenue, Welland SA 5007.

Referring Health Professionals please ensure your patient has the Enrolment forms found on our website at www.arthritissa.org.au under the Health Professional tab at the top of the page. They will not be able to participate in the program without them.