Arthritis ACT Medical Screening Process

1. Complete the **ESSA Adult Pre-Exercise Screening System form**.

2. Answer all 6 questions.
   a. If you answer **"no"** to all 6 questions, please sign the ESSA form and then complete and sign the **Arthritis ACT Warm Water Exercise Disclaimer**.

   b. If you answer **"yes"** to any of the 6 questions, please sign the ESSA form and then have your Medical Practitioner complete and sign the **Arthritis ACT Hydrotherapy Pool Medical Clearance Form.** You will also need complete details of your next of kin.

3. Return all signed forms to Arthritis ACT via email info@arthritisact.org.au, in person or by post.

Scroll down for forms

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: ______________

Warm Water Exercise - Disclaimer

Informed Consent/Disclaimer

By signing this disclaimer

I…… of
(Please Print Full Name)

………
(Full address) **(Phone Number)**

consent to participate in Arthritis ACT's warm water exercise sessions ('the program') and acknowledge unconditionally that I have given an accurate account of my health, any relevant medical conditions and my swimming ability. I acknowledge that it is solely my responsibility to advise Arthritis ACT if my medical status, health and/or swimming ability 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 swimming ability will affect my safe participation in the program, it is my responsibility to consult a doctor or other appropriately qualified healthcare professional.

I also accept that there are risks involved in any therapeutic water activity. I have been advised of pool rules and I am aware of factors relating to fatigue and dehydration from exercising in water. I have freely consented to participating in the program with full knowledge and appreciation of and acceptance of the risks to my own personal safety, including drowning.

Signature:………………………………………………………………………………………Date:……/………/……

Arthritis
AUSTRALIAN CAPITAL TERRITORY (ABN 25 538 506 729)

PO Box 908
Belconnen ACT 2616
Phone: 1800 011 041
Fax: (02) 6251 2066
Website: www.arthritisact.org.au
Email: info@arthritisact.org.au

HYDROTHERAPY POOL MEDICAL CLEARANCE FORM

Dear Doctor,

Your patient would like to attend a program of Warm Water Exercises for people with Arthritis, conducted by the Arthritis Foundation of the ACT. These sessions take place at hydrotherapy pools heated to between 30° and 36°C (usually around 34°C), are attended by up to 10 people and supervised by volunteers trained in CPR & Pool Rescue. The participant carries out a customised activity designed by an exercise physiologist. This environment is not necessarily suitable for everyone wishing to use the pools for warm water exercise.

Conditions which **exclude a person from using the pools because they may affect others** include:

- Incontinence
- Open wounds
- Infections – such as urinary, skin, eye, ear.

Please turn over the page and fill in the **Medical Status** on the back.

I believe that the person named below is able to walk, dress and get into & out of a pool and move around in the water unaided (some pools have steps and handrails) and is medically fit to use the hydrotherapy pools for the purpose of warm water exercise.

I have filled out this person's Medical Status on the back of this form and declare that the information I have given is accurate to the best of my knowledge as at the date below.

Patients Name: ____________________

Doctors's Name: ____________________ **Signature:** ____________________
(Please Print)

Date: ____________________

Patient Agreement

I...
(Please Print Full Name)

....
(Full Address) **(Phone Number)**

hereby apply to participate in the Warm Water Exercise programs organised by Arthritis ACT and I have read and will comply with the Arthritis ACT Pool Rules.

I can swim YES/NO
I would like to request to have a carer attend pool sessions with me YES/NO

Signature:..**Date:**..................

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.

Next of Kin:......................................**Ph:**...................

Medical Status

Patient Name: ____

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

[ ] Abnormal Blood Pressure__________________

[ ] Cardiac Problems ________________

[ ] Respiratory Conditions ___________________

[ ] Diabetes _______________________

[ ] Incontinence B/B ________________________

[ ] Recurrent Middle Ear Infection _____

[ ] Epilepsy _____________________________

[ ] Skin Conditions_________________

[ ] Joint Replacements ______________________

[ ] Kidney Disease _________________

[ ] Mild Stroke/Parkinson's disease/Multiple Sclerosis_______________________________

[ ] Recent surgery (past 12mths) _______________

[ ] Tinea/Verrucae _____Contraindicated

[ ] Pregnancy – Special clearance form required

[ ] Open wounds ______Contraindicated

[ ] Other

____

If you agree that your patient is able to participate in warm water exercises, are there any aspects of the patient's health that supervisors should be aware of?

____

____

____

____

Is there any medication that your patient MUST bring to the poolside with them? YES/NO

If yes, please state which medication(s)

____

Please turn over the page and sign the declaration on the front.

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