Gym/Fitness Therapy
Approval Form

Health Partners
Your Health Insurance Partner

Patient Details

Member number

Name *(first name)* *(surname)*

Date of birth / /

Referring Registered Provider Details

To be eligible for a Gym/Fitness benefit, the approval must be completed and signed by a Health Care Provider registered and recognised by Health Partners.

Referring Provider Name

Referring Provider Speciality

Provider number

Address

Postcode

Phone

Program Recommendation Details

Program referred ☐ Gym ☐ Yoga ☐ Personal Training ☐ Aqua-based ☐ Community Health Program

Please indicate the medical condition that the Health Program is intended to manage or improve

☐ Diabetes ☐ Weight Management ☐ Osteoporosis ☐ Arthritis ☐ Rehabilitation ☐ Asthma ☐ Backpain

☐ Orthopaedic (musculosketal) conditions ☐ Cardiac related risk factors (eg high blood pressure, raised cholesterol)

For any conditions that are unable to be described by the above categories, please supply further documentation confirming the condition.

Declaration

- I certify that I have recommended a program that is part of a health management program for the patient listed above and all the information on this form is true and correct.
- I confirm that this recommendation is valid for a period of 2 years unless otherwise advised.
- I declare that I have disclosed any financial interest in referring to a specific business or treatment.

Referring Healthcare professional signature Date / /