

SFL ENROLMENT FORM

SFL Facility Name: _____

Name: _____

DOB: _____

Suburb: _____

Post Code: _____

Telephone: _____

Gender: _____

Email Address: _____

Country of Origin: _____ Language spoken at home: _____

Do you identify as Aboriginal or Torres Strait Islander: _____

Referral Source:

- | | | |
|---|--|--|
| <input type="checkbox"/> Medical Practice | <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Rehabilitation Services |
| <input type="checkbox"/> Falls Prevention Service | <input type="checkbox"/> Health Clinic | <input type="checkbox"/> Healthy Lifestyle Program |

If self-referred, where did you hear about the Strength for life Program?

- | | | |
|---|--|--|
| <input type="checkbox"/> Local Newspapers | <input type="checkbox"/> COTA SA Publication | <input type="checkbox"/> Friend/Family |
| <input type="checkbox"/> Social Media | <input type="checkbox"/> Presentation from COTA SA | <input type="checkbox"/> Website |

What was the reason to start Strength Training?

- | | | |
|---|---|---|
| <input type="checkbox"/> Medical recommendation | <input type="checkbox"/> Social interaction | <input type="checkbox"/> To improve strength |
| <input type="checkbox"/> Preventative action | <input type="checkbox"/> Weight management | <input type="checkbox"/> To help after injury |
| <input type="checkbox"/> Stay fit and healthy | <input type="checkbox"/> Chronic disease management | <input type="checkbox"/> Improve Balance |

I agree that information regarding my enrolment in the Strength for Life Program can be used for promotion and evaluation of the program. Information collected will be treated confidentially.

Signed: _____

Date: _____