

PATIENT DETAILS

Name: Date of Birth: / /

Address:

Phone (M): Phone (H):

SERVICES REQUESTED

<input type="radio"/> Nutrition Clinic (Accredited Practicing Dietitian)	<input type="radio"/> Nutrition & Exercise Clinic (Accredited Sports Dietitian)	<input type="radio"/> Resting Metabolic Rate Testing
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EXERCISE TESTS

iDXA SERVICES

<input type="radio"/> Running <input type="radio"/> Cycling (Please bring your own bicycle)	<input type="radio"/> iDXA scan - Body Composition
<input type="radio"/> VO _{2max} test*	iDXA Clinical Indications (please tick at least one):
<input type="radio"/> VO _{2max} test with lactate response*	<input type="radio"/> Suspected/high risk of Relative Energy Deficiency in Sport (RED-S)
<input type="radio"/> Submaximal test (estimate VO _{2max})	<input type="radio"/> Weight loss, suspected or confirmed reduced energy availability
<input type="radio"/> Full hydration and fluid balance assessment	<input type="radio"/> Suspected/high risk of endocrine disturbance or impaired bone health
<input type="radio"/> Gut assessment (during exercise)	<input type="radio"/> Body composition assessment/monitoring/setting safe targets for optimal health/performance
<input type="radio"/> Carbohydrate & fat oxidation rates	<input type="radio"/> Limb asymmetry or wasting post-injury or surgery
<input type="radio"/> Heat stress test	<input type="radio"/> Metabolic syndrome, assessment of visceral adipose tissue

*Requires medical clearance prior to testing (see below)

REFERRER DETAILS

Name:

Address:

Phone: Fax: Email:

Discipline: General Practitioner Sport and Exercise Physician Accredited Sports Dietitian
 Accredited Practicing Dietitian Accredited Sports Scientist/Exercise Physiologist (ESSA)
 Other:

Report to be sent via: Mail Email Fax Request additional referral pads

VO_{2max} testing: I certify that the person listed above is a patient of mine and is fit to participate in incremental exercise testing to exhaustion (NB. must be completed by a medical practitioner).

Signature: Date:

Copies to:

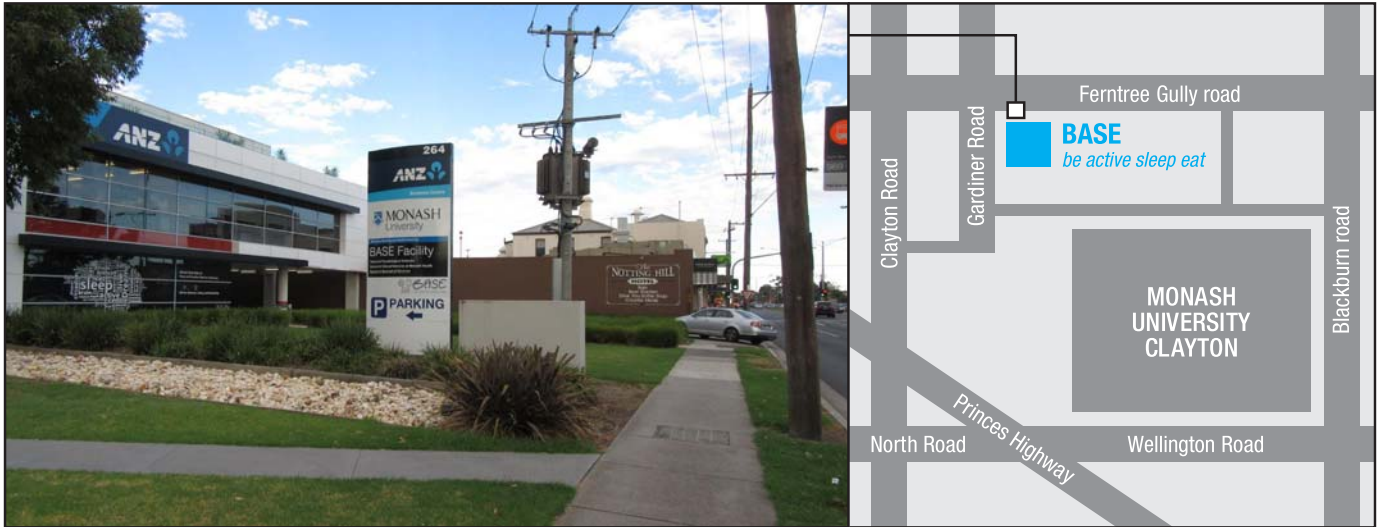
Reason For Referral/Clinical Information:

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PREPARING FOR YOUR TEST

- iDXA Body Composition – Please bring photo ID as well as this referral form. This test requires you to fast from 10pm the night before the test - that is, no food or drink other than water from 10pm. These tests will be given priority appointment times in the morning to reduce the amount of time fasted.
- Resting Metabolic Rate – this test requires you to fast from 10pm the night before the test. That is, no food or drink other than water from 10pm. These tests will be given priority appointment times in the morning to reduce the amount of time fasted.
- Exercise tests – Running: Please bring attire and footwear suitable for treadmill running
Cycling: Please bring your own bike, and attire for cycling

GETTING TO BASE (The BASE facility is located on Ferntree Gully Rd, next door to the Notting Hill Hotel)



CONTACT US

Be Active, Sleep Eat (BASE)

Address: Level 1, 264 Ferntree Gully Road Notting Hill VIC 3168

Telephone: 03 9902 4270

Email: base.nutrition@monash.edu

Web: med.monash.edu.au/base/eat

OFFICE USE ONLY

Photo ID Sighted (DXA only):

Pre-scan questionnaire completed:

Scan Date:/...../.....