Bader Gym User charges

	Disabled rate	Referral rate	Standard rate
One-off Induction	£10	£10	£10
Cost per session	£2	£3	£4

Disabled rate users: To qualify for this rate a person should be in receipt of disability living allowance. Please bring proof of this to your induction.

Referral rate users: Referrals will be accepted from a client's GP, physiotherapist, occupational therapist, dietician or any relevant medical professional.

Referrers: Please complete the referral form and give it to the client to bring to the Gym. Alternatively send it by post to the Bader gym. We will contact the client to arrange an induction. Induction charges apply to all new referrals.

Standard rate users: For members of the general public who do not qualify for Disabled or Referral rate.

To book an induction: Call 020 8487-6040. Leave a message on the answer phone and a member of staff will return your call.

On the first visit to the Bader Gymnasium your photo will be taken and you will be issued with a membership card. Changing areas and showers are available at the gym, but please bring your own padlock to ensure the safety of your personal belongings.

CSP048113 05/12

St George's Healthcare NHS
NHS Trust

BADER GYMNASIUM

QUEEN MARYS HOSPITAL
ROEHAMPTON LANE
LONDON
SW15 5PN
TELEPHONE: 0208 487 6040

REFERRAL FORM

- This form is to be used for the referral of patients/clients who would benefit from using the exercise facilities at the Bader Gymnasium.
- Inductions will be completed by a Fitness Instructor and include a one-to-one or group induction. Inductions take place on a daily basis and may require more than one session with an instructor. An exercise program will be provided to all new clients to meet individual client needs.
- Relevant user charges will apply to all new referrals. See overleaf for details.

PATIENT'S NHS NUMBER:.....

CLIENT DETAILS

Mr / Mrs / Miss / Ms M / F D.O.B: ____/____/____

Surname:_____

Forename:_____

Address: _____

_____

_____ Postcode:_____

Tel Home: _____ Tel Work: _____

Emergency contact number:_____

Patients GP: _____

Address:_____

_____ Postcode: _____

GP Tel: _____

Referred by: Name: _____

Signature: _____

Contact no: _____

This form will not be accepted without a GP stamp

Date: _____/_____/_____

REFERRAL DETAILS

Diagnosis:

Previous medical history

Comments/Reason for referral:

Is the patient you are referring registered disabled please circle Yes / No