MELBOURNE
SPORTS & ALLIED HEALTH
CLINIC

NAME:

DATE:

TIME:

Before undergoing any physiological assessment, you must bring all completed forms to your consultant, including the risk assessment sheet and informed consent for exercise testing / blood sampling.

ADDRESS: **DR SIMON SOSTARIC**
Melbourne Sports & Allied Health Clinic
Suite 1, 75 Keilor Rd Essendon VIC 3040.

PHONE: (03) 9374 4077 **FAX:** (03) 9374 4088
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INSTRUCTIONS:

1. Complete all forms prior to testing; please call with medical queries prior to testing.
2. Do not exercise on day of test.
3. If exercising the day before testing, ensure light exercise only.
4. Avoid meals & caffeine <4 hours prior to testing, or as directed.
5. Bring running or cycling attire. For cyclists, you are welcome to bring your own pedals.
6. Medical Supervision – please provide details of your medical history that may require medical clearance and/or medical supervision.

RISK FACTOR ASSESSMENT QUESTIONNAIRE

NAME: ..... DATE: .....

ADDRESS: .....

.....POSTCODE:……

AGE:.....(Yrs) DOB: .....GENDER:M○F○WEIGHT:..... (kg) HEIGHT:..... (cm)

(Mob.) ..... (Email).....

Person To Contact In Case Of Emergency

NAME: ..... RELATIONSHIP:……

ADDRESS: .....

PH: (W) ..... (H) ..... (M): .....

MEDICAL HISTORY:
In the past have you ever had (tick No or Yes)

	NO	YES		NO	YES
Stroke	☐	☐	Congenital Heart Disease	☐	☐
Myocardial infarction (heart attack)	☐	☐	Disease of Arteries/Veins	☐	☐
Angina Pectoris	☐	☐	Asthma	☐	☐
Heart Murmur	☐	☐	Other Lung Disease	☐	☐
Heart Rhythm Disturbance	☐	☐	Epilepsy	☐	☐
Rheumatic Fever	☐	☐	Injuries to back, knees, ankles	☐	☐

List any prescribed medications being taken

.....

.....

Other illness (Give details)

.....

.....

.....

ALLERGIES: Do you have any allergies **NO** ☐ **YES** ☐

If yes, give details: **.....**

……

SYMPTOMS DURING OR AFTER EXERCISE

As a result of exercise, have you ever experienced any of the following:

	NO	YES		NO	YES
Pain or discomfort in the chest, back, arm, or jaw	☐	☐	Palpitations (heart rhythm disturbance; racing heart)	☐	☐
Severe shortness of breath; breathing problems with during mild exertion	☐	☐	Pain in the legs during mild exertion	☐	☐
Dizziness, nausea or fainting	☐	☐	Severe heat exhaustion; heat stroke	☐	☐

CARDIOVASCULAR RISK FACTORS:

Do you have (tick No, Yes, or circle?)	**NO**	**YES**	**DON'T KNOW**	
High Blood Pressure	☐	☐	☐ ?	
High Blood Cholesterol/Triglycerides	☐	☐	☐ ?	
Smoking Habit	☐	☐	Ex. Sm☐ker	Average/day....
Diabetes	☐	☐	☐ ?	
Do you drink alcohol regularly	☐	☐		Average/day...

FAMILY MEDICAL HISTORY:

Have members of your immediate family ever had any of the following conditions: (tick No, Yes or circle?). If you answer Yes or ?, write beside this the member of the family affected (F=father, M=mother, B=brother, S=sister, GM= grandmother, GF=grandfather).

	NO	YES		FAMILY MEMBER	AGE (Years)	ALIVE NOW? (Y/N)
Myocardial infarction (heart attack)	☐	☐	☐	_____	_____	_____
Angina Pectoris	☐	☐	☐	_____	_____	_____
Stroke	☐	☐	☐	_____	_____	_____
High Blood Pressure	☐	☐	☐	_____	_____	_____
High Blood Cholesterol/triglycerides	☐	☐	☐	_____	_____	_____
Diabetes	☐	☐	☐	_____	_____	_____
Cancer	☐	☐	☐	_____	_____	_____

PERSONAL LIFESTYLE:

A. Exercise. List the sports, exercise or physically active hobbies (eg. gardening or playing with the kids) that you are **currently** engaged in:

Sport/Activity	Day(s) of week	Time of the day	Approx. duration

B. Nutrition

List a typical day's eating pattern.

Breakfast	Lunch	Dinner	Snacks	Drinks

C. Rest/Recreation

How many hours sleep do you usually have? .....hours/

On average how much time do you spend each day on passive hobbies or just relaxing .....min/hrs

Do you feel that you usually get enough restful sleep and time to relax? **Yes** ○ **No** ○

Declaration

I declare that the above information is to my knowledge true and correct, and that I have not omitted any information requested on this form.

SIGNED:

DATE:

OFFICE USE ONLY

CLEARANCE TO UNDERGO AN EXERCISE TEST

This person has been cleared to undergo a fitness test:

- ☐ Without medical supervision
- ☐ With medical supervision
- ☐ A fitness test is not advisable at this time

Signed:.....

Other Information:

Current Training Phase:…….

Rest: Time to bed:…… Time arising……..

Food Intake: last major meal.....am ○ pm ○

Food type amount……

Notes:

INFORMED CONSENT FOR GRADED EXERCISE TEST
(without medical supervision)

1. EXPLANATION OF THE GRADED EXERCISE TEST

- You will perform a graded exercise test on a cycle ergometer or a motor-driven treadmill. Exercise intensity will begin at a level you can easily accomplish (~50% effort) and will be advanced in stages commensurate with your functional capacity. Intensity increases every 1-3 minutes (the exact protocol will be confirmed on the day of test). For those completing longer incremental steps (e.g. 3 min), multiple blood lactate samples from a fingertip or earlobe drop of blood may be taken, in order to determine metabolic responses to exercise. We may stop the test at any time if contraindicative signs or symptoms occur, or if you are experiencing overwhelming symptoms of fatigue or discomfort. We do not wish you to exercise at a level which is abnormally uncomfortable for you. For maximum benefits, exercise as long as is comfortable.

2. RISK AND DISCOMFORTS

- There exists the possibility of certain changes occurring during the test. They include abnormal blood pressure, fainting, disorders of heart beat, and in extremely rare instances, heart attack, stroke or death. Every effort will be made to prevent adverse events by preliminary screening, and careful monitoring during the test. Should you feel any symptoms of discomfort of any kind, indicate this to us and we will terminate the test immediately.

3. RESPONSIBILITIES OF THE PARTICIPANT

- Information you possess about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of your exercise test. You are responsible to fully disclose such information on the accompanying sheets or when requested by the testing staff. Furthermore you are expected to disclose any feelings of discomfort during the exercise test. The staff will take all reasonable precautions to ensure the safety and value of your exercise test but we can not be held responsible in the event that you fail to disclose important information to us.

4. BENEFITS TO BE EXPECTED

- The results obtained from the exercise test assist in the evaluation of the types of physical activities (including frequency, volume, intensity) you can engage in with no or low hazards. Furthermore, specific training guidelines can be provided to maximize on expected adaptations.

5. INQUIRIES

- Any questions about the procedures used in the graded exercise test or in the estimation of functional capacity are encouraged. If you have any doubts or questions, please ask us for further explanations.

6. MEDICAL SUPERVISION

- Your cardiovascular risk factor and medical history do not indicate a need for a physician to be in attendance during this fitness test. However, we will arrange for a medically supervised test if you prefer.

7. FREEDOM OF CONSENT

- Your permission to perform this graded exercise test is voluntary. You are free to deny consent now or withdraw consent at any time (including during the exercise test) if you so desire.

- I have read this form and I understand the test procedures and the conditions under which this test will be conducted. I consent to participate in this fitness test without medical supervision.

.....

Name of Applicant **Signature of Applicant** **Date**

.....

Name of Witness **Signature of Applicant** **Date**

Exercise Physiologist Signature: .....

INFORMED CONSENT FOR DRAWING A BLOOD SAMPLE

With your informed consent, we would like to take a blood sample(s) for the following purpose:

☐ to assess your fitness level (eg. lactate).
☐ to assess your health status (eg. lipids, glucose, pathology screening)
☐ as part of a research project.

Due to the nature of the tests, we suggest that the following method of blood sampling would be most appropriate in your case.

☐ **skinprick** of a fingertip, using an autoclix (similar to test kit used by diabetics). You will feel a small prick on your finger tip when the sample is taken.
☐ **venepuncture,** which involves a needle prick into a vein in your arm; a sample (up to 8 ml) is then drawn off into a vacutainer. We use needles with small diameters in order to minimize the discomfort.
☐ **venous catheterisation** which involves the introduction of a small plastic tube or catheter (up to 2cm long) into a vein in your arm. In this case, the catheter will usually remain in your arm for the duration of the test. Only the plastic tube is left in your arm; the needle is withdrawn as soon as the catheter is in place. Catheters are used when several blood samples are needed from one site, because once the catheter is in place, it is a simple and painless procedure to remove a blood sample.

PRECAUTIONS TAKEN

A. Venepuncture, Venous catheterisation & capillary skinprick methods

We only use **clean** equipment and **safe** aseptic techniques. The risk of cross-infection is negligible. For venipuncture, venous catheterization and capillary (skinprick), only **sterile single use** needles, plastic tubing, syringes and dressings are used.

B. Fainting

Occasionally people faint when having a blood sample taken. Staff in our clinic is trained to manage fainting.

C. Bruising

Occasionally bruising may occur as a result of blood sampling, but we practice techniques that minimise this problem. Should bruising occur, it should resolve within 1-2 days. If **swelling** and **tenderness** occurs, please let us know immediately; if you are unable to contact us, you should consult with your doctor.

	Yes	**No**	**Not Likely**
Have you ever fainted when you have had an injection or blood sample taken.	☐	☐	
Do you have any of the following conditions?			
- Bleeding disorders (eg. hemophilia)	☐	☐	☐
- Clotting problems	☐	☐	☐
- H.I.V. positive (the A.I.D.S. virus)	☐	☐	☐
- Hepatitis B or C	☐	☐	☐
Have you ever been prescribed drugs to prevent blood clotting? (eg. warfarin, heparin).	☐	☐	☐

If yes to any of the above, give details;

……

……

DECLARATION AND CONSENT

I have read the information overleaf and provided complete and accurate details under the Risk Factor Assessment. Furthermore, I consent to having a blood sample(s) taken by the method indicated overleaf.

Name:
.....

Signed: ..... Date:

Witness: ..... Date:

Additional information - Ingestible thermometer safeguards

If you are undertaking heat tolerance assessments, a number of measurements will be made in order to assess changes in core and skin temperature. Core temperature will be monitored via a small ingestible thermometer (core pill), swallowed ~4hrs with water prior to testing. The core pill will unknowingly be excreted from your body within ~24hrs. Core temperature monitoring allows us to monitor your heat load responses and ensure safety during heat tolerance and acclimation sessions. Skin thermistors will also be applied to various anatomical sites in order to record changes in skin temperature. None of these body temperature recording devices cause any discomfort.

Please inform clinic staff if you have a history of having difficulty swallowing food or medium/large capsules. The ingestible temperature capsules will not generally used in those with any known or suspected obstructive disease of the gastrointestinal tract including, but not limited to; esophageal stricture, diverticulosis and inflammatory bowel disease (IBD), peptic ulcer disease, Crohn's disease, ulcerative colitis; previous gastrointestinal surgery.