HEART STRONG FITNESS

Fax: 1-888-508-6080

# Heart Strong Fitness Referral Form

Please include any recent testing results and records (ie discharge summary, ECG, lipids, Holter, Echo, MIBI, stress test, Framingham score, spirometry or PFT, XRay, CT scan, MRI) to assist in exercise prescription.

## Client Information

Last Name: _____ First Name: _____ DOB: (yyyy/mm/dd)_____

Address: (street, city, province, postal code)

_____

Telephone Number: _____

Alternate Telephone Number: _____

Email Address: _____ Allergies: _____

Alternate Contact Name: _____ Phone: _____

## Client Medical Information (completed by physician)

Family Physician: _____ Specialist: _____

Primary Diagnosis: _____

Risk Factors and Considerations:

- ☐ Tobacco use
- ☐ Excess Weight
- ☐ Hypertension
- ☐ ETOH
- ☐ Diabetes or Pre-Diabetes
- ☐ Abnormal Lipid Levels
- ☐ ICBC Claimant
- ☐ LTD Claimant
- ☐ Neck pain
- ☐ Back pain
- ☐ Hip Pain
- ☐ Shoulder Pain

Secondary/Other Diagnosis: _____

Activity Limiting Factors or Contraindications: _____

Clients must be medically stable and will be given an individualized exercise program based on initial assessment. Exercise prescription by a Certified Exercise Physiologist or Practicing Kinesiologist will include all or some of the following: cardiovascular exercise, resistance training, balance and functional training and stretching, unless limitations are suggested: _____(eg: ceiling HR max)_____

Referring Physician Name: _____ Physician Signature: _____ Date: _____

## Client Release of Information Authorization

I hereby authorize release of my medical records to Heart Strong Fitness by my physician or hospital.

Patient Name: _____ Patient Signature: _____

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