Health Care Professional Referral form

(to be completed and signed by a Healthcare Professional)

Name ______________________________ **Age** __________

Address ____

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Telephone______________________ **Email** ______________________

Please provide details on conditions & special considerations in each health category where applicable.

Program:

Cardiovascular:
Musculoskeletal:
Respiratory:
Other:
Medications (Please list or attach a printed list of your patients current medications)

PARmed-X Physical Activity Readiness Conveyance Referral Form

Based upon a current health status review of , ____________________ I recommend:

- ☐ No Physical Activity
- ☐ Progressive physical activity______________________________
- ☐ With avoidance of______________________________
- ☐ With inclusion of______________________________
- ☐ Unrestricted physical activity-start slowly and build up gradually.

______________________________ ____________________

Health Care Professional **Date**

Please send this completed form to:
Abilities Centre, 1 Jim Flaherty Street, Whitby ON L1N 0J2
postrehab@abilitiescentre.org | Fax: 289-278-4418

Abilities Centre™