The Heart, Health & Breath – Wellness Program Referral Form

Participants must be medically stable and able to function in a group. Please include a list of current medications.

CLIENT INFORMATION

Last Name: _____ **First Name:** _____

Date of Birth *(yyyy/mmm/dd):* _____

Address: _____

City: _____ **Postal Code:** _____

Home Number: _____ **Cell Number:** _____

Email: _____

Emergency Contact Person: _____ **Relationship:** _____

Home Number: _____ **Cell Number:** _____

Family Physician: _____ **Office Number:** _____

Specialist: _____ **Office Number:** _____

CLIENT MEDICAL INFORMATION *(Completed by Physician or Specialist)*

Allergies? □ NO □ YES – please list: _____

_____

Heart Disease? □ NO □ YES – please list medications & dosage: _____

_____

COPD? □ NO □ YES – please list medications & dosage: _____

_____

Other Medical Conditions? □ NO □ YES – please list medications & dosage: _____

_____

Comorbidities:

- □ Tobacco Use
- □ Excess Weight
- □ Hypertension
- □ ETOH
- □ Diabetes or Pre-Diabetes
- □ Abnormal Lipid Levels
- □ Home Oxygen Therapy
- □ Inactivity
- □ Anxiety or Depression

Activity Limiting Factors or Contraindications: _____

_____

Clients will take part in a supervised exercise program based on initial assessment. Exercise prescription will include all or some of the following: cardiovascular exercise, resistance training, balance and functional training and stretching, unless limitations are suggested above.

Referring Physician's: _____ **Physician's Signature:** _____ **Date:** _____

CLIENT RELEASE OF PERSONALINFORMATION

I hereby authorize the release of my medical records to the Heart, Health & Breath – Wellness Program by my physician or hospital.

Client's Name: _____ **Client's Signature:** _____ **Date:** _____

Fax or email client's completed form **ATTENTION: Heart, Health & Breath Wellness Program**

FAX NUMBER: 250-339-0814 or email info@comox.ca