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.
Fax or email completed form attention: Heart, Health & Breath Wellness Program
FAX NUMBER: 250-339-0814 and hbailey@comox.ca

CLIENT INFORMATION

Last Name: _____ First Name: _____

DOB: (yyyy/mon/dd) _____

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

Telephone Number: _____ Alternate Telephone Number: _____

Email Address: _____ Allergies: _____

Emergency Contact Name: _____ Phone: _____

Referring Practitioner: _____ Specialist: _____

CLIENT MEDICAL INFORMATION (COMPLETED BY PHYSICIAN)

o Heart Disease_____ o COPD_____
o Other medical conditions (please list)

Comorbidities:

o Tobacco use	o ETOH	o Home Oxygen Therapy
o Excess Weight	o Diabetes or Pre-Diabetes	o Inactivity
o Hypertension	o Abnormal Lipid Levels	o Anxiety I 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 Practitioner Name: _____ Practitioner Signature: _____
Date: _____

CLIENT RELEASE OF INFORMATION AUTHORIZATION

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

Patient Name: _____ Patient Signature: _____