Referral/Intake Form

Name: M/F: Date:

Phone :(H) Phone: (W) ext. Date of Birth:

Address:

City: Postal Code:

Email:

Emergency Contact Person: Phone:

MEDICAL CONDITION		CARDIOVASCULAR
☐ Knee Replacement/Injury	Right/Left	☐ Stroke
☐ Hip Replacement	Right/Left	☐ Heart Surgery
☐ Osteopenia		☐ Angioplasty
☐ Osteoporosis		☐ Angina
☐ Osteoarthritis		☐ Defibrillator
☐ Cancer – Type:____________		☐ Pacemaker
Date of Diagnosis:____________		☐ Myocardial Infarction
Treatment: ☐Chemotherapy ☐Radiation ☐Surgery ☐Other		
☐ Other – Please note: ____________		**RECOMMENDED PROGRAM(S):** ____________

RISK FACTORS/SIDE EFFECTS: (Controlled by medications Yes/No-please circle)

☐ Smoking	Yes/No	☐ Inactivity	Yes/No	☐ Depression/Anxiety	Yes/No
☐ Hypertension	Yes/No	☐ Overweight	Yes/No	☐ Stress	Yes/No
☐ Diabetes Type____________		☐ Dyslipidemia	Yes/No	☐ Allergies____________	
☐ Skin Problems	Yes/No	☐ Low Blood Counts	Yes/No	☐ Bone Metastases	Yes/No
☐ Visual Disturbance	Yes/No	☐ Nausea/Vomiting	Yes/No	☐ Neuropathy/Loss of Sensation (hands/feet/both)	Yes/No
☐ Balance/Dizziness	Yes/No	☐ Aphasia	Yes/No		
☐ Recent fall	Yes/No	☐ Painful Joint______	Yes/No		

Family Physician/Specialist Signature Physician/Specialist:

PLEASE PRINT

Limitations/Restrictions/Contraindications:

Name of Specialist/Health Care Team

FOR OFFICE USE ONLY:

Date Received: Received By: Referral by:

Intake Appt.: Orientation Appt.:

Date: Date:

Assigned Trainer/Program: Occupation:

Treatments: (ie. Physiotherapy)

Surgery, Chemotherapy, Hormone Therapy:

Additional Medical History Notes:

Diagnosis Date:

Current Medications:

1. 2. 3.

4. 5. 6.

7. 8. 9.

Program Completion Date: Program Completion Date:

RETURN TO:

☐ **Flamborough Family YMCA**
Fax (905) 690-7410
Phone (905) 690-3555

☐ **Hamilton Downtown Family YMCA**
Fax (905) 529-6682
Phone (905) 529-7102

☐ **Ron Edwards Family YMCA**
Fax (905)333-1767
Phone (905) 632-5000

☐ **Brantford Family YMCA**
Fax (519)759-8431
Phone (519) 752-6568

☐ **Les Chater YMCA**
356 Rymal Road East
Hamilton, ON L9B 1C2
Fax (905) 667-5879
Phone (905) 667-1515

YMCA
We build strong kids,
strong families, strong communities.

Hamilton Health Sciences

FOR OFFICE USE ONLY:

Step 1	Complete pre-exercise health risk assessment with YMCA staff. Physician's clearance to exercise may be required.	Step 7	Design exercise program- Maximize Benefits/ Minimize Risk
Step 2	Register in appropriate program	Step 8	6 Week follow up, double check established guidelines
Step 3	Tour of YMCA facility, Membership Registration	Step 9	12 week follow up, double check established guidelines
Step 4	Complete baseline fitness testing if appropriate	Step 10	Ensure information entered in database
Step 5	Participation in first exercise session		
Step 6	Schedule follow up intervals for physical testing if appropriate		

What are your personal goals for participation at the YMCA? Short term and long term? ____________________

Briefly list the reasons why you think the YMCA will be beneficial for you? ____________________

What is your general state of health?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

On average how would you describe your energy level?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

When during the day is your energy best? ____________________

Do you currently exercise? ____________________

What form? ____________________

How often? ____________________

Are there any activities/exercises that your doctor has recommended you avoid? ____________________

Are there any unusual symptoms during or after exercise? ____________________

Do you have any side effects or symptoms as a result of your medical condition or treatment?
i.e dizziness, nausea, loss of sensation, balance ____________________

Is there a family history of any specific medical condition? ____________________

Are there any specific physical aids that you require? i.e.walker, hearing aid ____________________

During regular daily activities is any special assistance required? i.e. transportation, housekeeping ____________________

Are you currently monitoring blood sugar levels (diabetes)? ____________________

What are your blood sugar levels before and after exercise and do you eat before activity? ____________________

Would you like us to communicate with your physician on your participation at the YMCA? ____________________

Blood pressure ____________________

Height ____________________

Weight ____________________

BMI ____________________

Waist to hip ratio ____________________

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