



Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Phone: \_\_\_\_\_

### CanWell – Cancer Exercise & Education Program EXERCISE REFERRAL FORM

#### MEDICAL INFORMATION

##### REFERRING DIAGNOSIS & DATE:

Cancer type: \_\_\_\_\_

Date of Diagnose: \_\_\_\_\_

##### TREATMENT:

- Surgery       Chemotherapy       Radiation  
 Immunotherapy

Treatment ended: \_\_\_\_\_

Notes: \_\_\_\_\_

##### RELEVANT PAST MEDICAL HISTORY:

- Diabetes       PAD       Cardiac  
 Hypertension       Other \_\_\_\_\_

IS PATIENT ON BETA-BLOCKER MEDICATION:  Yes  
 No

RECOMMENDED TO MEASURE BLOOD GLUCOSE PRE AND POST EXERCISE:  Yes       No

*HYPOGLYCEMIA IS CONTRAINDICATION FOR EXERCISING*

#### RISK FACTORS/SIDE EFFECT

- skin problems  
 PICC line  
 Aphasia  
 incontinence  
 Spinal cord compression  
 Back pain  
 Other pain \_\_\_\_\_

#### EXERCISE CONTRAINDICATIONS/ LIMITATIONS/ RESTRICTIONS

- Surgical Precaution  
 Lifting Restriction  
 Bone metastatic disease  
 Low blood counts  
 Neuropathy

**Financial Assistance Required**

#### OTHER NOTES:

#### FOR COMPLETION BY REFERRING PHYSICIAN

OFFICE STAMP

Name of Referring Physician: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date: \_\_\_\_\_

*This information contained within this referral has been discussed with the patient*

PHIPA format email to: [corinne.norris@ymcahbb.ca](mailto:corinne.norris@ymcahbb.ca)