Shine On

Hamilton Health Sciences

McMaster University

Patient Name:

Address:

Birthdate:

Phone:

In Motion – Bone and Joint Health Program
EXERCISE REFERRAL FORM

MEDICAL INFORMATION

REFERRING DIAGNOSIS & DATE:

☐ Osteoarthritis ☐ Rheumatoid Arthritis

☐ Osteoporosis ☐ Total Joint Replacement

☐ Mobility ☐ Other _____

TREATMENT:

☐ Surgery ☐ Medication ☐ Physiotherapy

Surgery Date: _____

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

☐ Fractures
☐ Falls in last year
☐ Lost **2 cm or more (¾")** in height
☐ Lost **6 cm or more (2½") in height in adulthood**
☐

Notes: (Dates, fracture location)

EXERCISE CONTRAINDICATIONS/ LIMITATIONS/ RESTRICTIONS

☐ Surgical Precaution

☐ Lifting Restriction

☐ Gait Aid

☐ Hip/Knee Restrictions post-surgery

☐ **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: christine.smith@ymcahbb.ca