TIERED EXERCISE PROGRAM REFERRAL FORM

Referred By: _____Phone: _____ Date: _____

Client Information:

Name: _____ Phone: _____ DOB: dd /mm/ yyyy

Street Address_____ _____Apt # _____ City: _____Postal Code: _____Male / Female

Preferred Language:_____

Living Arrangement: Alone Spouse/Friend Family Member

Smoking in home: Yes No Pets in home: Yes No DNR: Yes No

Known behavioral aggression of client/resident of same household? Yes No

Walking Aid: Yes Type: _____ No

Falls History •None within the last 12 months •1 or more in the last 12 months •Unknown

Client Health Conditions/ Reason for Referral:

_____

_____

Family Physician Name: _____Phone Number: _____

Health Card #: _____Version Code_____Expiry Date: _____/____/_____

Emergency Contact

Full Name: _____Relation: _____
Phone_____

Substitute Decision Maker/POA Yes No **Copy may be requested by agency for file*

Eligibility Criteria please circle all that apply:

- Ontario Resident with valid Ontario Health Card
- Not Currently Receiving Physiotherapy
- Medically Stable
- Fall Risk Functional Decline
- Able to recall information & follow instructions **OR** has frequent support for assistance YES NO

To arrange services please call:

_____

Please Fax Referral to 905 685 6651 Attn: Community Support Supervisor TEP

Questions: Ph: (1) 905 687 8484 x255