(Patient Label or Complete)
Date:

Name:
DOB (Month/Day/Year):

Patient ID#:

Exercise Professional Referral Form

Referral Information

Reason for referral (check all that apply):

- ☐ Deconditioning
- ☐ Acute Injury
- ☐ Chronic disease (e.g. cancer, T2DM)
- ☐ Balance problems
- ☐ Fatigue
- ☐ Pregnancy
- ☐ Chronic Pain
- ☐ Return to Work/School
- ☐ Cognitive dysfunction
- ☐ Neurological impairment
- ☐ Other: _____

Comments:

Medical Comorbidities

Cardiac ☐ Hypertension ☐ Myocardial infarction ☐ Valvular heart disease ☐ Coronary artery disease ☐ Arrhythmia ☐ Congestive heart failure ☐ Vascular disease ☐ Stroke ☐ Pre-syncope/Syncope ☐ Deep vein thrombosis **Other** ☐ _____	**Metabolic** ☐ Pre-Diabetes ☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Thyroid disease **Musculoskeletal/Neurologic** ☐ Osteoarthritis ☐ Inflammatory arthritis ☐ Osteoporosis ☐ Osteopenia ☐ Chronic myofascial pain ☐ Neuropathy ☐ Bone metastases	**Mental Health** ☐ Anxiety ☐ Depression ☐ Cognitive dysfunction ☐ Fatigue **Pulmonary** ☐ COPD ☐ Asthma ☐ Pulmonary hypertension ☐ Pulmonary embolus **Renal** ☐ Kidney disease

Notable Medications:

Activity Clearance

(see the CSEP Get Active Questionnaire for more information)

- ☐ Unrestricted progressive physical activity
- ☐ Physical activity with supervision by an Exercise Professional
- ☐ Physical activity with restrictions: _____
- ☐ No moderate/vigorous physical activity and further investigations suggested:

_____

Referring Physician

Would you like to receive communication regarding this patient? Yes No

Physician Name: _____ Signature: _____

Billing#: _____ Contact (fax/email): _____