Referral 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: _____	

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		

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:
Initial:		Initial:
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.