(Patient Label or Complete)
Date:

Name:
DOB (Month/Day/Year):
Patient Phone Number:

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

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