REFERRAL SCRIPT: UW WELL-FIT EXERCISE PROGRAM

Name of Client:	Phone:
Email:	Date of Birth:

Referral for UW WELL-FIT exercise program.

- ☐ In treatment
- ☐ Post treatment (within 2 years)

***Note*:** All programs are fully or partially funded. Fees will be outlined during initial contact and will depend on available funding.

Cancer Medical Information:

Type of cancer	Date of diagnosis
Type of surgery	Date of surgery

Treatment protocol:	**Chemotherapy**	**Radiation Therapy**	**Hormonal Therapy**
Drug			
Frequency			
Start date			
Length of treatment			
Finish date			

Resting Heart Rate		Resting Blood Pressure	

Additional Medical Concerns:

☐ cardiovascular	
☐ metabolic	
☐ musculoskeletal	
☐ other	

This patient is cleared to participate in one of the following:

- ☐ progressive physical activity with avoidance of: _____
- ☐ unrestricted physical activity (start slowly and build up gradually)

Referred By: (Please print)	Designation:
Signature	Date

Fax to UW WELL-FIT: 519-888-4033

CCCARE staff will call the patient to book an assessment (519-888-4567 Ext. 46841)