



Dr. Paul Schwann Centre Referral

Name: Hospitalization #: / /
Address: Postal Code:
Home Phone: Cell Phone:
Date of Birth (dd/mm/yy): SGI WCB Claim #

Reason for Referral (Please check one only):

- Love2Live (Cardiac Rehabilitation and Risk Reduction/Lifestyle changes)
TIA/Stroke
COPD
Musculoskeletal Injury/Exercise Therapy
Personal Training
Rock Steady Boxing (Parkinson's Patients only)
ENRICH Community Neurorehab Program

Musculoskeletal Diagnosis/ Finding/ Contraindications:

Blank lines for Musculoskeletal Diagnosis/ Finding/ Contraindications

Medical History:

- Normal OR Coronary Heart Disease (or prone to)

Risk Factors Present (Please check all that apply):

- Cigarette Smoking
Dyslipidemia
Diabetes Mellitus IDDM or NIDDM (Please circle one)
Family Hx Premature CHD
Hypertension
Obesity

Other Significant Medical Conditions (Please check and comment):

Cardiac Client
Myocardial Infarction
CABG
PTCA
CAD
Valvular Disease
Other (please explain)
Accidents
Allergies
Epilepsy
Infections
Mental Illness, Neurological Impairment
Osteoporosis, Osteopenia
Respiratory Disease
Other

Laboratory Data (if available):

Blood Pressure: _____ / _____ Medicated: Yes No
Blood Lipids: Total -C _____ HDL-C _____ LDL-C _____ TG _____ Hemoglobin _____
Fasting (Please check one): Yes No Blood Glucose: _____ HbA_{1c}: _____

12 Lead Electrocardiogram: (Please check & attach if available):

- Not available
- Within Normal Limits
- Abnormal (Please explain)

Present Medications (Type & Dosage): _____ **OR** See Attached

Date of last physical examination: ___/___/____ (dd/mm/yyyy)

Other Comments:

IMPORTANT: The above-listed person is capable of participating in a laboratory controlled physical fitness under the direct guidance and supervision of:

- Laboratory Technician/ Exercise Physiologist** **OR** **Physician**

(Please check one)

Referring Physician (Please print): _____ Telephone: () _____

Signature: _____ Date: / / (dd/mm/yyyy) _____

Please return to patient, mail or fax to:
Dr. Paul Schwann Centre
University of Regina, Regina, SK S4S 0A2
Fax: (306) 585-5363 Tel: (306) 585-4004

For more information on our programs and services or to download referral forms, please visit our website at <http://www.uregina.ca/dpsc>