Physical Activity Services
Fax Referral for Health Care Providers

Fax completed referral to: 250-953-0493

☐ I confirm that the patient and/or their legal representative have authorized this referral. I confirm that they have the appropriate capacity to consent to this referral.

Patient / Practitioner Information:

Patient Name: _____

Gender: _____

Personal Health Number: _____

Date of Birth: _____

Date of Referral: _____

Phone Number: _____

Referring Practitioner: _____

Office Address: _____

_____

Office Phone: _____

Office Fax: _____

Total # of Pages: _____

Check All That Apply:

☐ Arthritis:_____
☐ Cancer:_____
☐ Cognitive Impairments/Behavioral Disorders:_____
☐ Diabetes (☐ Type 1 ☐ Type 2 ☐ Pre-diabetes)
☐ Gastrointestinal
☐ Heart Condition
☐ Hypertension
☐ Mental Health Conditions
☐ Metabolic Disorder:_____
☐ Muscle, tendon/ligament, joint injury
☐ Neuromuscular Condition
☐ Obesity
BMI (if available):_____
☐ Osteoporosis
☐ Other:_____
☐ Physical Inactivity
☐ Renal Disease
☐ Respiratory Disease:_____
☐ Sleep disorder
☐ Spinal Cord Injury
☐ Stroke

Past Medical History / Other Health Concerns: (Use additional pages as needed)

Additional Information or Investigations: (Use additional pages as needed)

Medications: (Use additional pages as needed)

Translation Services Needed? Specify Language: (130 languages available) _____