

NEURO FIT PROGRAM

REFERRAL FORM

Program Description:

- For clients with neuro based mobility disorders (MS, PD, SCI, ABI, CVA etc.)
- Circuit style exercise Program (cardio, strength, agility, balance, postural stretching)
- 2 trained Instructors: 10 participants max, evidence based
- 2 days week x 1 hour x 12 weeks
- Financial assistance available for those who qualify

Criteria: Participants **MUST** answer **YES to ALL** in order to participate in the program

Please answer ALL questions

		YES	NO
1	Transfer independently/Stand by assist/ provide own assistant	<input type="checkbox"/>	<input type="checkbox"/>
2	Toileting independently	<input type="checkbox"/>	<input type="checkbox"/>
3	Able to understand English	<input type="checkbox"/>	<input type="checkbox"/>
4	Able to follow verbal/ written instructions	<input type="checkbox"/>	<input type="checkbox"/>
5	Able to exercise in a group setting (does not require 1:1 supervision)	<input type="checkbox"/>	<input type="checkbox"/>
6	Able to communicate needs effectively (verbally and non verbally)	<input type="checkbox"/>	<input type="checkbox"/>

Referral made by: _____ Phone #: _____

Patient Name: _____ Date of Birth: _____ PHN#: _____

Address: _____ Phone #: _____ Email: _____

Emergency Contact: _____ Phone#: _____

Neuro Diagnosis: _____ Other Diagnosis: _____

Mobility status: _____ walks independently _____ walks with an aide _____ wheelchair user

This section must be completed by GP: Please indicate any exercise restrictions

Doctor Name: _____		Doctor's Signature: _____	
Cardio	No restrictions	Restrictions	_____
Balance	No restrictions	Restrictions	_____
ROM	No restrictions	Restrictions	_____

Please fax completed referral form to Brennan Park Recreation Centre 604.898.4035
For more information please contact Heidi Drygas at heidi.drygas@vch.ca or 604 892 2293 local 234