



## Limestone Health Consultants and Kingston Body Management Referral Form

Client Name: \_\_\_\_\_ Sex: M  F

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Cell: \_\_\_\_\_

Reason for Appointment:  Weight Loss  Diabetes Program  Stroke Rehabilitation

Cardiac Rehabilitation  Weight Management for Kids

Orthopaedic  Prevention Program  Other \_\_\_\_\_

Program Interested in:  Group Fitness Program  Individualized Program

Physiotherapist Supervision Required? Yes  No

Relevant Medical Conditions: \_\_\_\_\_

Attach any medical reports deemed necessary including hospital Cardiac Rehab Discharge Reports

\*Please have client bring a complete list of medications.

**NOTE: ECG Stress Test is required for entry into the Cardiac Rehabilitation Program.**

\*Please provide a copy of stress test results when available.

Referring Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_