



PHYSICIAN REFERRAL FOR:

Check type of referral requested

Falls Clinic Assessment (by Geriatrician, Nurse, Physiotherapist)

Falls Prevention Exercise Program (4) week, education & exercise)

Date:

Phone: (905) 472-7387

NOTE: Please include all pertinent lab reports and consultation notes with this completed form.

Patient Name		Last	First	Phone:
				()
Address		Street, Apt.#		City
		Province	Postal Code	
Date of Birth	Day, Month, Year		Sex:	Health Card No.
Contact Person:				
Relationship to Patient:			Phone:	()
Fall History:				
Present Health Problems:				
Past Health Problems: (including any allergies, addictions, etc.)				
Present Medications:				
Physician Name:				
Address:			Phone	()
Physician Signature:				
OFFICE USE ONLY	Date of Falls Clinic Assessment:		Start Date of Exercise Program:	

