

**NOTE: Incomplete and / or unsigned requisitions will be returned**  
 MARKHAM STOUFFVILLE HOSPITAL CORPORATION

PLEASE PRINT CLEARLY  
 OR AFFIX LABEL WITH COMPLETE INFORMATION

**FALLS PREVENTION CLASS REFERRAL**

Dr. Raza Naqvi, MD, FRCPC

Markham Site Booking Line: (905) 472-7601  
 Fax: (905) 472-7621

Patient Name (Last, First): \_\_\_\_\_  
 Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Sex: F M  
 Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone # (Best Daytime): \_\_\_\_\_  
 Alternate #: \_\_\_\_\_  
 Email: \_\_\_\_\_

Date	Referring Provider	Signature	Provider Phone #	Provider Fax #
Family MD/NP (if different from Referring Provider)	Family MD/NP Phone #	Family MD/NP Fax #	Registration #	

Additional Reports to:

Translator/contact person for scheduling	Language spoken if other than English <b>Please bring translator to appointment if required</b>
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Is client/substitute decision maker aware of referral?  
 Yes  No

<p><b>Criteria for Referral</b></p> <ul style="list-style-type: none"> <li>✓ Referred by health care provider</li> <li>✓ History of falls</li> <li>✓ Fear of falling</li> <li>✓ Motivated to participate in classes</li> <li>✓ Able to participate in light to moderate exercises</li> <li>✓ Able to follow instructions (translators welcome)</li> <li>✓ Able to complete standing exercises with supervision and cueing only</li> </ul>	<p><b>Exclusion criteria</b></p> <ul style="list-style-type: none"> <li>✗ Requires hands on assistance for exercises</li> </ul>
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Participants using mobility aid are welcome (e.g. walker or cane)

**Medical Information**

Medical history:  Documentation/notes attached

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Medications:  Documentation attached

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Other:

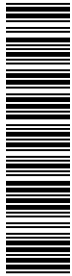
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**NOTE: Patient/family will be contacted directly with class date/time**