

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 Please bring translator to appointment if required		
Is client/substitute decision maker aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<p>Criteria for Referral</p> <ul style="list-style-type: none"> ✓ Medical clearance to participate in a regular exercise program ✓ History of falls ✓ Fear of falling ✓ Cognitive ability/interest in participating in program ✓ Able to follow instructions (translators welcome) ✓ Able to walk 25 m with supervision ✓ Able to complete standing exercises with light support <p style="text-align: center;">Participants using mobility aid are welcome (e.g. walker or cane)</p>				
Medical Information				
Medical history: <input type="checkbox"/> Documentation/notes attached				
Medications: <input type="checkbox"/> Documentation attached				
Other:				

NOTE: Patient/family will be contacted directly with intake assessment date/time

