McMaster University

Mac Warriors

Cancer Rehabilitation Services

PACE
McMaster Physical Activity Centre of Excellence

For completion by Referring Physician

I wish to refer my patient to MacWarriors Cancer Rehabilitation Services to participate in physiotherapy and/or an individualized exercise program in order to maximize their quality of life and cancer recovery. Based on a recent review of this client's health, they are safe to participate in:

☐ Range of Motion/Soft Tissue Mobilization

☐ Progressive moderate physical activity
Limitations at this time include: _____

☐ Other (please specify): _____

Certification Statement: *I have received authorization from this patient to release the information below and to permit the staff of the Mac Warriors Cancer Rehabilitation Services to contact him/her directly for follow-up.*

Name of Referring Physician: _____ **Telephone**: _____

Physician Signature: _____ **Date:** _____

Patient Information

Name: _____ **Diagnosis:** _____

Telephone: _____ **Date of Birth (MM/DD/YY):** _____

Due to the complexity of cancer and its treatment, working openly and collaboratively with a client's physician is of utmost importance. Any additional information you feel would be pertinent to this client's care would be greatly appreciated.

_____

_____

Return to: McMaster Physical Activity Centre of Excellence (PACE)
Department of Kinesiology, McMaster University
Ivor Wynne Centre, Room E114
Email: macwarriors@mcmaster.ca
Phone: 905-525-9140, ext. 27223
Fax referral form to: 905-525-7629