McMaster University | Physical Activity Centre of Excellence

MacWarriors Cancer Exercise Program
Physician Referral Form

For completion by Referring Physician
I wish to refer my patient to MacWarriors Cancer Exercise Program to participate in a physiotherapy assessment and individualized exercise program. Based on a recent review of this patient's health, they are safe to participate in physical activity as tolerated.
Certification Statement: I have received authorization from this patient to release the information below and to permit the staff of the McMaster Physical Activity Centre of Excellence to contact him/her directly for follow- up.
Name of Referring Physician:________________________ **Telephone**: ____________________
Physician Signature:________________________________ **Date:** ______________________
Patient Information
Name: ________________________________ **Date of Birth (MM/DD/YY):** __________________
Telephone:_____________________________ **Diagnosis:** _______________________________
Please include any additional information pertinent to this patient's care (treatments/interventions, medications, symptoms, limitations, risk factors, comorbidities):

Please return form to:

McMaster Physical Activity Centre of Excellence (PACE)
McMaster University, Ivor Wynne Centre, Room E114
1280 Main Street West
Hamilton, Ontario L8S 4L8
Phone: 905-525-9140, ext. 27223
Fax referral form to: 905-525-7629