**Referral and Medical Clearance Form**

http://intranet3/BaycrestWork/Tools_and_Resources/Baycrest_Branding/images/COLORlogo_SMALL.gif

**Community Falls Prevention Program**

€ Male € Female

Name of Client (First/Last Name)

Address (Number & Street Name)

Postal Code

Apt City Province

Phone Number

Health Card Number /Version Code

DOB (DD/MM/YYYY)

The Community Falls Prevention Class includes a group education and discussion session (20 minutes). Followed by seated warm-up (10 minutes), moderate level standing strengthening exercises with hand support (10-20 minutes with rests) and balance activity such as foam pads (1:1 supervision). Please advise:

**The patient is able to participate in a group balance exercise class of 30-60 minutes.**

**Please check:**

* **Yes**
* **No**

Please provide any contra-indications or precautions to participation:

Physician Name:

Address:

Phone #: Fax #:

Date: Physician signature:

Should you require any further information, please contact the Fitness & Health Promotion Department at 416-785-2500 x 2555. You may fax this form directly to 416-785-2496.