

Medical Report for Exercise Class Participation

Preamble: Sufficient medical information for persons referred to our community programs and services is often not provided to assist us in providing care. Your assistance is greatly appreciated.

Client Surname: _____ Given: _____

Address: _____
Street name

_____ City Province Postal Code

Diagnosis and date of onset: _____

Brief health history (include medical/surgical, social, psychiatric):

List any drug sensitivities, allergies, addictions: _____

Present condition (include any behavioural, social, emotional concerns):

Name of client's pharmacist: _____

Phone number of pharmacy: _____

I, _____, _____
physician name (please print) physician signature

give my recommendation for _____ to attend
client's name (please print)
 exercise classes with Lumacare.

Phone number of physician's office: _____ Date: _____