Referral Form

HYPERION
EXERCISE AND HEALTH

F: 587-441-8383
P: 587-355-1723

Patient Information

Name: _____ DOB: _____

PHN: _____ Referral Date: _____

Phone: (C) _____ (H) _____

Address: _____

City: _____ Province: AB Postal Code: _____

Clinical Information

Primary reason for referral: _____

Relevant diagnosis: _____

Relevant medical history: _____

Relevant precautions: _____

Relevant medications: _____

Service(s) Requested

- ☐ Medically Focused Exercise
- ☐ Health Coaching/Behaviour Change
- ☐ Active Rehabilitation (Exercise Therapy)
- ☐ Movement/Functional Assessment
- ☐ Counselling/Psychology
- ☐ Resting Metabolic Rate Test (Mobile)
- ☐ VO2 Max Testing (Mobile)
- ☐ Physiotherapy
- ☐ Concussion Management
- ☐ Dietetics

Referring Provider

Name: _____

Clinic Name: _____

Clinic Fax: _____

Signature: _____

Attachments

- ☐ Relevant Consult Note(s)
- ☐ Imaging Report(s)
- ☐ Lab Result(s)
- ☐ Medication List
- ☐ Operative Report

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