Referral Form

HYPERION
EXERCISE AND HEALTH

F: 587-441-8383

Patient Name: _____ DOB: _____

Date of Injury: _____ Referral Date _____

Phone: (C) _____ (H) _____

Address: _____

Diagnosis: _____

_____

- ☐ Motor Vehicle Accident (MVA)
- ☐ Extended Health Care Benefits
- ☐ Private Pay

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

OUR LOCATIONS:

☐ **Tele-Health**

Tel: (587) 355 1723
Fax (587) 441 8383
info@hyperionhealth.ca

☐ **Home Health**

Tel: (587) 355 1723
Fax (587) 441 8383
info@hyperionhealth.ca

Referring Name: _____ Signature: _____

CLINIC STAMP

www.hyperionhealth.ca