Community Support Connections
Meals on Wheels and More

OSTEOARTHRITIS EXERCISE REFERRAL FORM

FOR PATIENT USE

First Name:		**Last Name:**	
Address:		**Home Phone:**	
City:		**Birth Date:** *(mm/dd/yyyy)*	
Email:			

Gender: ☐ **Male** ☐ **Female**

Language Spoken: ☐ **English** ☐ **French** ☐ **Other:**

FOR CLINICIAN USE

Osteoarthritis Status

Affected Joint				**Pain Levels**	
Hip OA		**Knee OA**		1-10 **at rest**	1-10 **with movement**
L	R Both	L	R Both	_____	_____

Contraindications – conditions affecting exercise participation

Contraindications:

Referring Health Practitioners Name — Contact Number

Referring Health Practitioners Signature

Patient Signature

Please fax to 519-648-3737 attn: Jenn McDonald