



Toronto Rehabilitation Institute
A University of Toronto
Teaching and Research Hospital
 HC LC BC RC UC

FITNESS CENTRE
Referral Form

Please print clearly

Spinal Cord Rehab Program

Fax # 416-597-7042 / Phone # 597-3422 ext 6188 or 6151

Applicant Information

MRN # _____
Tor Rehab # _____

OHIP #: _____

Name: _____

Physician Information:

Address: _____

Physician Name: _____

Phone: _____

Address: _____

DOB: _____

Phone: _____

Diagnosis: _____

ASIA Score: _____

Other Medical Conditions: Does the applicant suffer with any of the following conditions (please check all that apply and provide details for each)

	No	Yes	Details
Autonomic Dysreflexia (AD)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tendinopathy/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Syrinx	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Atrial Fibrillation (AF)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Known CAD / Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes / Abnormal Glucose tolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____

Based on the above information is serum screening / arm ergometry or myocardial perfusion scan indicated prior to exercise prescription?

Yes No



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Medications: (name and dosage. Please indicate any exercise related precautions)

Based upon a current review of the health status of the above named applicant, I recommend:

- Unrestricted physical activity
- Progressive physical activity
 - With avoidance of: _____

With inclusion of: _____

- No physical activity

Referring Physician Signature: _____ **Date:** _____