Generously Funded by: Ontario — Erie St. Clair Local Health Integration Network / Réseau local d'intégration des services de santé d'Érié St. Clair

VON SMART

Move to be STRONG!

VON CANADA

www.vonsmart.ca

To:	VON SMART Team
Date:	
Fax:	Windsor-Essex 519-254-1588 / Chatham-Kent 519-352-2466
Phone:	Windsor-Essex 519-254-4866 Ext. 6239 / Chatham-Kent 519-352-5515 Ext. 5225
Re:	Referral for - VON Exercise & Fall Prevention Program

☐ Rest & Retirement Group ☐ Community Group ☐ In-Home 1:1

_____ [Name] is interested in participating in an exercise program for people who have challenges with balance and mobility and/or wishes to be more physically active.

Note: This program provides exercise for health and wellness, not physiotherapy. It offers exercises to address strength, balance and endurance. Classes can be done seated and/or standing and include:

- Functional movements that practice activities of daily living such as standing up from a chair, walking, reaching and bending, stepping on and off steps. Supports are provided for balance.
- Light to moderate aerobic exercise; 45-60 minutes of exercise
- Fall Prevention education is incorporated
- A supportive environment with a safe staff to participant ratio

If your patient has any of the following, he/she may not be suitable for this program: Please indicate if either of the following apply: ☐ Uncontrolled angina ☐ Uncontrolled hypertension ☐ Orthostatic Hypotension

Is a support person needed to assist with personal care needs (i.e. washroom) ☐ Yes ☐ No

Is your patient medically stable and safe to participate in exercise ☐ Yes ☐ No

Can your patient walk by him/herself 10m, with or without a walking aid? ☐ Yes ☐ No

Does your patient have a history of, or currently have the following (check all that apply)

- ☐ Stroke
- ☐ MS
- ☐ Acquired Brain Injury
- ☐ Cognitive and/or behavioural issues
- ☐ Diabetes
- ☐ Peripheral vascular disease
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Frequent Falls
- ☐ Chronic Pain
- ☐ Other _____ _____ _____

Does your patient have a history of (check all that apply):

☐ Cardiac Arrest ☐ Congestive Heart Failure ☐ Asthma/COPD that worsens with activity

Do "Hip Precautions" apply? ☐ Yes ☐ No In effect until: _____

Considering all aspects of my patient's medical history, I agree that _____ does not have any health issues that would prevent him/her from participating in the exercise program as described.

Referring Professional's Name (print): _____ Phone: _____

Patient Name: _____ D.O.B._____ HC#_____

Address: _____Phone Number: _____

Alternate Contact Name: _____ Phone: _____ Relation: _____

Special Instructions: _____
_____
_____