

Physical Activity Services - Oncology Telephone Referral Form

Referrals accepted from specialist physicians and primary care providers

Referring Physician/Nurse Practitioner:	Patient:	
	PHN:	
Address:	DOB:	
Phone #:	Gender:	
Fax #:	Address: Phone #:	
	Alt. Phone #:	
Data a Car Canada	THE THORE II.	
Date of referral:		
☐ I confirm that the patient has authorized this referral.		
Additional Information – e.g. best time to call, contact person/name, need for translation service/preferred language:		
Reason for referral:		
☐ increase physical activity levels ☐ manage fatigue ☐ build/maintain muscle and bone mass ☐ balance ☐ other		
☐ Patient can engage in physical activity without restrictions — 150 minutes of moderate to vigorous aerobic		
activity and two resistance training sessions per week ¹		
☐ Patient can engage in physical activity with restrictions		
☐ Patient cannot engage in any physical activity		
Tatient cannot engage in any physical acti	vity	
Please List Restrictions:		
Relevant Medical History		
Cancer type: Stage:		
If metastases please check location: □ bone □ lung □ brain □ other		
Please attach relevant blood work and imaging results (i.e. location and type of bone metastases)		
Treatment - Current Recent treatment (com	pleted<12months)	ompleted >12 months)
☐ Chemotherapy ☐ Radiation	☐ Surgery	
Details:		
Documents attached:	☐ Consultation letters	\square Other
Please fax the co	ompleted referral form:	
Attn: Physical Activity Services at HealthLink BC		
Fax number: 250-953-0493		
Email: physicalactivity@gov.bc.ca		

Schmitz K, et al. American College of Sports Medicine Roundtable on Exercise Guidelines for Cancer Survivors. MSSE. 2010; 42(7):1409-26

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