Referral Form to the TIME™ Program

(To be completed and signed by Physician, or Allied Health Professional)

Name:	
Address:	
Phone Number:	**Email:**
Emergency Contact/Relationship:	**Emergency Contact Number:**

_____ [name] is interested in participating in Together In Movement and Exercise (TIME™), a group exercise program for people who have challenges with balance and mobility. Fitness instructors lead the exercise program, which was designed by physiotherapists. Eligible persons are those who can walk a minimum of 10 metres with or without a walking aid.

This program provides exercise for health and wellness, not physiotherapy. It offers exercises to address strength, balance and endurance. Classes include:

- The practice of everyday activities such as standing up from a chair, walking, reaching and bending, and stepping on and off steps. Supports are provided for balance as needed.
- Light to moderate aerobic exercise; 1-hour of exercise, once or twice per week for about 12 weeks per session and up to 3 sessions per year.
- A supportive environment with a safe staff (fitness instructor and volunteer) to participant ratio.

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

Is a support person needed to assist with personal care needs (i.e., washroom)? ☐ YES ☐ NO

Is your patient presently 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 (Side affected_____) ☐ Diabetes ☐ Osteoporosis
☐ MS ☐ Peripheral vascular disease ☐ Severe joint pain preventing exercise
☐ Acquired brain injury ☐ Seizures: Date of last one: _____ Frequency: _____
☐ Cognitive and/or behavioural issues that may impede group participation ☐ Other medical conditions: _____

The following are precautions for which a graded exercise test/stress test is recommended. 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: _____

☐ **Please attach a printed list of your patient's current medications.**

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 (please print): _____ Phone #: (___) _____

Signature: _____ Date: _____

Participant or Guardians Signature:

Send completed form to:

Rachel Salsman: rsalsman@marchofdimes.ca , Tel: 403-473-4920; Fax: 403-263-8954