H.E.A.L.TH PROGRAM REFERRAL

Health, Exercise, Active Living and Therapeutic Lifestyle

Please FAX to 416-425-0301

Toronto Rehabilitation Institute
A Teaching Hospital of
the University of Toronto

Rumsey Centre
347 Rumsey Road, Toronto, Ontario M4G 1R7
Tel: (416) 597-3422 x.5200
http://www.uhn.ca/TorontoRehab/PatientsFamilies/Clinics_Tests/HEALTh

Name: _____

Address: _____ Apt: _____

City: _____ Postal Code: _____ Health Card # _____

Tel: (_____) _____ (_____) _____ DOB: _____/_____/____
Home Business (B) or Cell (C)

Relative or Contact Person: _____ Tel (____) _____
(Mandatory if patient does not speak English)

Patient Free from Metastatic Disease; NO ☐ YES ☐
If No, unfortunately the H.E.A.L.TH program is unable to support women living with metastatic disease at this time.

Breast Cancer Diagnosis:_____ Date of Diagnosis:_____ Affected Side: Right ☐ Left☐

Stage_____ ER/PR status: _____ HER2: +ve☐ -ve☐

Surgery: _____ Date:_____ Nodes: removed ____ +ve ____
Chemotherapy (ie. FEC-D): _____ From: _____ To: _____
Radiation Therapy: _____ From: _____ To: _____
Biological Therapy: _____ From: _____ To: _____
Hormonal Therapy: _____ From: _____ To: _____
Participated in double blind trial? (ie. Metformin): _____
Diagnosed with breast cancer related lymphedema? NO ☐ YES ☐ if yes: Limb ☐ Torso ☐

Reconstruction Surgery? NO ☐ YES ☐ _____ Procedure date: _____

****Please include most recent ECG and CBC****

Referring MD: Name: _____ Address: _____
Phone Number: _____ Signature: _____

☐
Family Practice ☐ Oncologist ☐ Cardiologist

Family Doctor: (if different than above)
Name: _____ Address: _____
Phone Number: _____

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Patient Waiver for Disclosure of Personal Health Information

_____ _____/_____/____
(Print) Last Name First Name Date of Birth (D/M/Y)

I hereby authorize Sunnybrook Health Sciences Centre to release to Toronto Rehab Institute any pertinent Medical Records or information concerning my recent admission. I understand that this information is to be used for the provision of heath care services.

Signature of patient/
Legal Representative: _____ Witness: _____ Date: _____
(or substitute decision maker)
Relationship (if not patient): _____ Print Name of Witness: _____