Client Referral

CLIENT

Name - First	
Name - Last	
HCN	
D o B	
Address - Street	
Address - City, Prov, Code	
Phone	
Worksafe/ICBC #, if applicable	

CONDITIONS REQUIRING TREATMENT

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GOALS OF TREATMENT

Check Goals of Treatment in the boxes below as appropriate:

Fitness		Weight Mgmt		Pre-op Rehab	
Mobility		Diabetic Mgmt		Post-op Rehab	
Pain Mgmt		Fall Prevention		Other	

PRECAUTIONS

Blood Pressure		Hot tub/sauna	Yes or No	Other

SIGNATURE

Attending Physician Signature: ____

Attending Physician Name: ____

Date: ____

Please FAX this completed Client Referral form to Recope 250-494-9006

Recope, Box 1625, Summerland, B.C. V0H 1Z0, Phone/Fax 250-494-9006, CRA Charity # 11915 8095 RR0001