TIME™ Program Participant Referral Form

(To be completed and signed by Physician, PT, or RN/NP)

Participant & Program Information — SECTION 1

Last Name: _____ First Name: _____

Phone #: _____ Email: _____

Address*: _____

*Please attach proof of residency.

The above person is interested in participating in TIME™, a group exercise program for those with balance & mobility challenges. Fitness Instructors &/or Certified Therapeutic Recreation Specialists lead the Physiotherapist designed exercise program. Eligible participants are able to walk a minimum of 10 metres with or without a walking aid. This program provides exercise for health & wellness, not physiotherapy. It offers exercises to address strength, balance & endurance.

Classes include:

- The practice of everyday activities such as standing up from a chair, walking, reaching, bending, & 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 up to 12 weeks per session & up to 3 sessions per year.
- A safe & supportive environment. 1:4 staff to participant ratio. Additional volunteers may be present.

Suitability — SECTION 2

1. If your patient has either of the following, they would **not** be suitable for this program. Please indicate if either of the following apply:
   ☐Uncontrolled angina ☐ Uncontrolled hypertension ☐ None
2. Is your patient presently medically stable to participate in exercise? ☐ YES ☐NO
3. Can your patient walk by themselves 10m, with or without a walking aid? ☐YES ☐NO
4. Does your patient use a walking aid? ☐ YES ☐ NO Type:_____

Support to Attend — SECTION 3

1. Is a support person needed to assist with personal care needs (i.e. washroom)? ☐YES ☐NO
2. Will your patient bring a family member or friend to the program? ☐YES ☐NO
   *If yes, list their Name: _____ Relationship: _____ Contact: _____

Precautions — SECTION 4

1. The following are precautions for which a graded exercise test/stress test is recommended. Please indicate if there is a history of the following? (check all that apply)

☐Cardiac arrest ☐ Congestive heart failure ☐ Asthma/COPD that worsens with activity ☐ None

2. Do “Hip Precautions” apply? ☐ YES* ☐ NO *If yes, in effect until: _____

CS- TIME™ Program Referral Form	Community Services

Medical History — SECTION 5

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

☐ Stroke ☐ Diabetes ☐ Osteoporosis ☐ Acquired Brain Injury
☐ MS ☐ Peripheral vascular disease ☐ Severe joint pain preventing exercise
☐ Cognitive &/or behavioral issues impeding participation ☐ Communication limitations
☐ Seizures - Date of last: _____ Frequency: _____ Duration: _____
☐ Other medical condition(s): _____

2. Is your patient currently taking medication that may potentially impact participation? ☐YES* ☐NO
***If yes, attach a list of current medications which may impact ability to participate in this program.**

Referral Information — SECTION 6

Considering all aspects of my patient's medical history, I agree that _____
Does not have any health issues that would prevent them from participating in the TIME™ Program.

Reference Name (please print): _____
Organization: _____
Phone: _____ Email:_____
Preferred method of contact if required: ☐ Phone ☐ Email

_____ _____
Signature Date

Privacy Notice — SECTION 7

Collection of personal information via this form is authorized under the Access to Information and Protection of Privacy Act, 2015 and is needed to process this application. Questions about the collection and use of the information may be directed to Inclusive Services at 576 8020 or inclusion@stjohns.ca.

Please return completed form and proof of residency to:	City of St. John's	**For Further Info:**
Inclusive Services	1 Crosbie Place	Phone: 709 576 6972/4450
Recreation Division	P.O. Box 908	Fax: 709 576 2308
	St. John's, NL AIC 5M2	Email: inclusion@stjohns.ca