

	CS – TIME™ Program Referral Form	Community Services
TIME™ Program Participant Referral Form (To be completed and signed by Physician, PT, RN/NP, CTRS or other Health Care Practitioners)		
Participant & Program Information		SECTION 1
Last Name _____ First Name _____ Phone _____ Email _____ Address _____ 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 Asthma/COPD that worsens with activity Congestive heart failure None		

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Precautions continued	SECTION 4
2. Do “Hip Precautions” apply?: Yes* No *If yes, in effect until _____	
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. Participation in the TIME™ program requires Health Care Practitioner referral. This information is needed to assess applicant suitability for the program. Questions about the collection and use of the information may be directed to Healthy City & Inclusion by emailing inclusion@stjohns.ca .	
Please send completed form and proof of residency to: Healthy City & Inclusion P.O. Box 908, 10 New Gower Street St. John’s, NL A1C 5M2 For further information: Phone: 709-576-6972 Email: inclusion@stjohns.ca HGR Mews Community Centre 60 Blackler Avenue	

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