ST. JOHN'S

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

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:

Inclusive Services
1 Crosbie Place

Healthy City & Inclusion
P.O. Box 908, 10 New Gower Street
St. John's, NL A1C 5M2

For further information:
Phone: 709 576 6972/4450
Email: inclusion@stjohns.ca

ST. JOHN'S
NEWFOUNDLAND AND LABRADOR, CANADA