Physical Activity Screening Form

Patient Label

Current Side Effects:
- Cardiotoxicity
- Pulmonary function
- Fatigue
- Bowel/bladder changes
- Neutropenia
- Anemia

Thrombocytopenia
Peripheral neuropathy
Decreased range of motion
Bone or joint issues
Lymphedema
Skin changes

Other (please indicate below):

Additional Comments:

Please indicate any significant co-morbidities [that could affect exercise participation]:

Is the cancer metastatic? If so, please provide the locations and stability of metastases.

Physical Activity Clearance:
- No physical activity at this time
- Under supervision of qualified exercise professional
- Unrestricted or progressive physical activity

Modification(s) for exercise (if applicable):

Physician Signature:

Stamp:

Date:

Patient Information:

Last Name: ____________________________  First Name: ____________________________
Address: ____________________________
City: ____________________________
Province: ____________________________
Postal Code: ____________________________
Email: ____________________________
Home Phone Number: ____________________________
Work Phone Number: ____________________________
Cell Phone Number: ____________________________
Gender: ____________________________
Date of Birth: ____________________________
Personal Health Number: ____________________________

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