MOVE FOR LIFE
SOUTH SURREY WHITE ROCK

Chronic Disease Management & Prevention Exercise Class Referral

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Date:

Patient Information:
Name:
DOB:
PHN:
Phone:

Reason for referral:

Please provide your written approval to indicate that this patient/individual is medically stable and can participate in the medically supervised exercise program at the Center for Active Living. Please complete and email it back to us as soon as possible.

□ ASAP □ suggested date: _______________

Comments: ____

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Primary Care Provider (Physician/Specialist/CDM nurse/Health care Professional)

Name:
Phone:
Fax:
Signature of referring Health Care Provider: ______________________________

Thank you for your attention to this matter and for working with us to ensure the safety of the patient/individual.

CDM Program Location:
Center for Active Living, Unit 1 – 1475 Anderson Street, White Rock, BC V4B 3C9

Funding Partners

Project Partner