wellspring
CANCER SUPPORT
SOUTIEN FACE AU CANCER
NEW BRUNSWICK
NOUVEAU-BRUNSWICK

Wellspring Cancer Exercise Program
Physician Consent Form

To be completed by applicant

PLEASE PRINT Please check one of the following: ☐Mr. ☐Mrs. ☐Miss. ☐Ms.

Last Name: _____ First Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Telephone: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____ Email: _____

To be completed by physiotherapist (optional)

Treatment	Comments
☐Exercise Program	_____
☐Pain Control	_____
☐Range of Motion	_____
☐Other: _____	_____

To be completed by physician (mandatory)

Our program is available to adults with cancer who have been diagnosed, are undergoing treatment or are in survivorship. We offer our program for 2 sessions per week for 12 weeks. All sessions are led by a physiotherapist, kinesiologist, and/or exercise physiologist.

The following list of criteria must be met for an individual to attend our program:

- Diagnosed with cancer
- Over 18 years of age
- Ability and motivation to participate in an exercise program

Cancer Diagnosis: _____ Stage: _____

Metastatic Lesion: ☐Y ☐N If yes, indicate location: _____

Additional comments/Comorbidities requiring consideration during exercise:

_____

_____

I give my consent for the above applicant to participate in the Wellspring Cancer Rehabilitation Program:

_____ _____

Physician Signature Date

Physician Address: _____

_____

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