

## Health and Wellness Referral

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Primary Care Provider Name: \_\_\_\_\_

Signature: \_\_\_\_\_

What is the Goal?

Comments:

- Manage a Medical Condition
  - Physiotherapy/Chiropractic/Injury Rehabilitation
  - Nutrition Counseling
  - Foot Care Clinic
  - Diabetes Exercise Program
  - Get Better Together (Manitoba-wide)
  - Other: \_\_\_\_\_
  - For Cardiac or Pulmonary Rehabilitation, please use existing Referral Forms
- Improve Strength and Fitness
- Healthy Weight Loss
- Healthy Eating
- Stress Management
- Quit Smoking

**Fax referrals to 204.633.3753**