Referral Form

Patient FIRST and LAST Name: _____

Date of Birth: _____ Age:

Address: _____

Home Phone: _____ Cell Phone: _____

Services Requested:

- ☐ 3D Running Assessment
- ☐ 3D Walking Assessment
- ☐ Physician Consultation – Dr. Sylvia Loewen*
- ☐ Dietitian Consultation – Janelle Vincent, RD
- ☐ Alter-G Treadmill
- ☐ VO2 Max Testing

*Please complete the Physician Referral Form in addition to this form.

75 Poseidon Bay
Winnipeg, MB R3M 3E4
204.927.2828