FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

# LIVESTRONG
## CHIPPEWA FALLS YMCA
## ONCOLOGIST REFERRAL FORM

**Name:** _____ **Date:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Gender: M F Date of Birth:** _____ **Age:** _____

## Cancer Information

**Cancer Type:** _____ **Date of Diagnosis:** _____

**Stage and Grade:** _____

**Specific Location(s):** _____

**Type of Treatment(s):** _____

**Treatment Start Date:** _____/_____/_____ **Treatment End Date:** _____/_____/_____

**Medical Concerns:** _____

_____

_____

**Exercise Concerns (check all that apply):**

_____ **No concerns**
_____ **No exposure to aquatic activities**
_____ **Limited mobility (please describe):** _____

_____

_____ **May participate in only non-weight bearing activities**
_____ **May have balance/coordination difficulties**

**Other exercise concerns (please specify):** _____

_____

**Referring Oncologist:** _____ **Date:** _____

**Please return this document via mail, email or fax to:**
**Tracey Quast, LIVESTRONG Instructor**
**Chippewa Falls YMCA, 611 Jefferson Ave, Chippewa Falls, WI 54729**
**Phone: 715.723.2201 Fax: 715.723.6063 Email: tquast@ymca-cv.org**