UWEC Cancer Recovery & Fitness Program
Oncologist Referral Form

Patient Information:

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Gender: M F

Age:_____ Date of Birth:_____

Cancer Information:

Cancer Type (i.e., breast, colon, etc.):_____

Date of Diagnosis:_____ Stage/Grade:_____

Specific Location(s):_____

Type of Cancer Treatment(s):_____
Beginning Date of Treatment:_____ Ending Date:_____

Medical Concerns:_____

_____

_____

Exercise Concerns (check all that apply):

No concerns……_____
May participate in only non-weight-bearing activities…….._____
No exposure to aquatic activities……_____
May have balance/coordination difficulties……_____
Limited mobility (please describe)……_____

_____

Other exercise concerns (please specify)……_____

_____

Referring Oncologist:_____Date_____

Please return, mail, or fax this document to:
Professor Matt Wiggins
Department of Kinesiology
University of Wisconsin—Eau Claire
105 Garfield Ave.
Eau Claire, WI 54702
Fax: (715) 836-4074