UWEC Exercise & Cancer Recovery 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 have the patient return, mail, or fax this document to:

Professor Matt Wiggins
Chair, Department of Kinesiology
University of Wisconsin—Eau Claire
105 Garfield Ave.
Eau Claire, WI 54702
Fax: (715) 836-4074