Sunnybrook
ST. JOHN'S REHAB

Tel: 416-224-6948
Fax: 416-226-3358

285 Cummer Avenue
Toronto, ON M2M 2G1

www.sunnybrook.ca/stjohnsrehab

PRE-HAB PROGRAM

WELCOME TO THE PRE-HAB PROGRAM!

Attached to this letter you will find:

1. General Information – Please retain for your records
2. Participant Application Form (Form 1)
3. Participants Release Form (Form 2)
4. Physician Consent Form (Form 3)
5. PAR-Q Form (Form 4)

Please forward completed forms and fees to:

St. John's Rehab
Outpatient Services
285 Cummer Ave.
Toronto, ON, M2M 2G1

Acceptance to the program is subject to:

1. Review of the Participant's Application and Physician Consent Forms
2. Receipt of payment

If you have any questions, feel free to call us at:

416-226-6780 x 7215

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GENERAL INFORMATION

Class Breakdown:

Classes consist of a combination of gentle strengthening exercises and balance routines to help individuals prevent furthered-conditioning. Known in advance of what to expect following your surgery, you will be provided with dedicated education sessions that will guide you through your upcoming rehabilitation process. Exercises are structured into a circuit of stations. Each station contains a unique exercise structure to improve a certain area of the body.

Fees Schedule:

- $100 per session. Each session includes 8 classes.
- There are no refunds or make-up times for missed classes.
- You may only attend class for your scheduled days.
- The fee includes all exercise classes

Please make cheques payable to: **St. John's Rehab**
To make payments in person please go to our Patient Accounts Department (located on the first floor)

Please make sure you have included all of the following:

1. Participant Application Form
2. Participant Release Form
3. Physician Consent Form
4. PAR-Q Form
5. Payment

* Incomplete applications will not be accepted

How to contact us?

Pre-Hab Program **416-226-6780 x 7215**

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PARTICIPANT APPLICATION FORM

Name:	**Date of Birth:**	**Date:**
Address:		
Home Phone:	**Alternate Phone:**	
Emergency Contact Name: **Emergency Contact Phone:**		

Reason for taking program (circle one): Post-rehab/Arthritic care/General conditioning/Fall Prevention/Other (Please Specify)_____

Which Session are you applying for:
1st Choice_____
2nd Choice _____
3rd Choice _____

How did you become aware of this program? _____

Please indicate if you have experienced any of the following conditions:

		If applicable, explain
Problems with bladder/bowel control	___No ___Yes	_____
Seizures – epileptic	___No ___Yes	_____
Fainting Spells	___No ___Yes	_____
Problems with blood pressure	___No ___Yes	_____
If yes, *High Blood Pressure* ☐		
Low Blood Pressure ☐		
Heart condition (e.g. angina)	___No ___Yes	_____
Diabetes	___No ___Yes	_____
If yes, do you require insulin?	___No ___Yes	_____
Breathing problems (e.g. asthma)	___No ___Yes	_____
Deafness	___No ___Yes	_____
Limited Vision	___No ___Yes	_____
Poor Balance	___No ___Yes	_____
Are you independently mobile?	**___No ___Yes**	_____

Other medical conditions or symptoms that may affect participation in the Program:

___No ___Yes If yes, explain: _____

Doctor's Name:_____ Doctor's Telephone Number : _____

*** **Please attach:** Physician Consent Form, Participant's Release Form, PAR-Q Form and Payment.

Reviewed by:
Date:

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PARTICIPANT RELEASE FORM

If my application for the Pre-Hab Program is accepted, I understand and agree that St. John's Rehab will not assume financial responsibility for any medical expense or compensation for any injury I may suffer either during or resulting from participation in this program.

Name: (Please print)_____
Last **First**

Signature: _____

Witness:_____

Date Signed:_____

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PHYSICIAN'S CONSENT FORM

Participant's Name: **Address:** **Phone Number:**	**Type of Arthritic Condition:**
Significant Past Medical History:	**Previous or Recent Surgery:**

The program includes 60 minutes of gentle exercises to help improve joint ROM, muscle strength, endurance and balance. Exercise intensity ranges from no resistance to light resistance depending on the patient's ability. Exercises are done in sitting or standing with support. This class is suitable for people who are independently mobile.

CONTRAINDICATIONS:

PRECAUTIONS:

ADDITIONAL COMMENTS:

Physician's Name:	Physician's Signature:
Phone:	Date:

For more information or questions please contact us at **416-226-6780 x 7215**