KINESIOLOGY REFERRAL FORM
Lyris Davis – Kinesiologist
Kaizen Fitness and Consulting

PATIENT INFORMATION:

First Name: _____Last Name: _____ Phone: _____

Personal Health Number: _____

Date of MVA: _____ Date of Birth: _____

ICBC Claim #: _____

PATIENT CONSENT AND RELEASE

I hereby voluntarily consent to participate in Kinesiology services with Lyris Davis of Kaizen Fitness and Consulting. I understand there are risks associated with an active rehabilitation program, and that I have the right to ask about these risks and have any questions about my condition answered prior to treatment.

I authorize my Health Care Professional and Lyris Davis of Kaizen Fitness and Consulting to release or obtain any medical history, assessment, testing and treatment results necessary to assist in the management of this claim for the duration of this claim.

Choose One:

- ◯ I am the client and I consent to the above paragraph
- ◯ I am the client's Health Care Professional and I have read the above paragraph to my client and have obtained my client's consent to the above paragraph

CLAIM DETAILS (Injuries, Diagnostics, Co-Morbidities/Contraindications/Restrictions)

REFERRING HEALTH CARE PROFESSIONAL:

Referral Date: _____

Referring Health Care Professional Name: _____

Clinic: _____

Fax Form To: (778) 401-0483 Email: kazienfitconsult@gmail.com Submit Ph: (250) 460-7570