

# Physician Referral

Date Faxed/Sent to Physician \_\_\_\_\_

Patient: \_\_\_\_\_ Physician: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dear Doctor,

Your patient has requested to participate in an exercise program. This referral is requested for establishing medical clearance to provide initial fitness assessments for beginning an exercise program.

Due to the reasons listed below, we are requesting medical clearance for your patient. Please complete the following form and state to the best of your ability if there are any contraindications or recommendations for participation in the testing procedures or exercise program. This form is administered based on established guidelines of the ACSM (American College of Sports Medicine). This referral is valid only if the client remains on the same medications (type and dose), and is in the same clinical status as on the day of the fitness assessment. The client has signed a statement that it is his/her responsibility to inform the trainer of any changes in their health status. Thank you.

Primary Risk Factors noted on Health History Questionnaire (for the Trainer only):

|   |  |  |
|---|--|--|
| <input type="checkbox"/> elevated cholesterol       | <input type="checkbox"/> cigarette smoking       | <input type="checkbox"/> high BP/BP meds |
| <input type="checkbox"/> sedentary                  | <input type="checkbox"/> metabolic disease       | <input type="checkbox"/> CV disease      |
| <input type="checkbox"/> age (males >45/women > 55) | <input type="checkbox"/> family history          | <input type="checkbox"/> pregnancy       |
| <input type="checkbox"/> BMI $\geq$ 30              | <input type="checkbox"/> signs or symptoms _____ |  |

Other information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Based on the information provided and any other information you, the physician, may have concerning your client, your recommendations for exercise (check ONE):

1.  is **NOT CLEARED** and cannot exercise at this time.
2.  is **CLEARED** and can exercise with no restrictions
3.  is **CLEARED** with the following RESTRICTIONS \_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_

\_\_\_\_\_ Date

**Please return within 1 week from date noted above.**