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)**:

_____ elevated cholesterol	_____ cigarette smoking	_____ high BP/BP meds
_____ sedentary	_____ metabolic disease	_____ CV disease
_____ age (males>45/women > 55)	_____ family history	_____ pregnancy
_____ BMI ≥ 30	_____ 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.

revised 6/12/02
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