Request for Physician Clearance for Exercise

Physician: _____

_____

Phone: _____

Patient: _____

DOB:_____ M _____ F _____

Phone: _____

Email: _____

Approval for release of information relevant to exercise:

_____

Signature

FITNESS & FUNCTION LLC

NW Mobile Health and Fitness Professionals

4804 NW Bethany Blvd. Suite 12 #167

Portland, OR 97229 / www.FitnessAndFunction.com

Call: 503-267-1030 / Fax: 971-228-8638

Email: info@fitnessandfunction.com

Requested by:

Dear _____,

Your patient has requested to participate in an exercise program. This referral is requested for establishing medical clearance for beginning an exercise program and/or initial fitness assessment. 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 participating in exercise or in testing procedures. This form is administered based on established guidelines of the American College of Sports Medicine (ACSM). This referral is valid only if the client remains on the same medications (type and dose), and is the same clinical status as on the day of the fitness assessment and initial exercise program. The client has signed a statement that it is his/her responsibility to inform the exercise specialist/trainer of any changes in their health status. Thank you.

- ☐ Elevated cholesterol
- ☐ Sedentary
- ☐ Age (male >45 female >55)
- ☐ BMI ≥ 30
- ☐ Cigarette smoking
- ☐ Metabolic disease
- ☐ Family history
- ☐ Signs or Symptoms _____
- ☐ High BP/BP meds
- ☐ CV disease
- ☐ Pregnancy
- ☐ _____

Other information: _____

_____

_____

_____

_____

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

Your Prescription for Health
Exercise is Medicine™
www.ExerciseIsMedicine.org

_____is **NOT CLEARED** and cannot exercise at this time

_____is **CLEARED** and can exercise with no restrictions

_____is **CLEARED** with the following **RESTRICIONS**

_____

_____

Do you desire to receive exercise information (symptoms, limitations, abilities, outcome of testing, and changes (improvement or decrement) in health related fitness? ☐ **No** ☐ **Yes**, how do you prefer to receive this:_____

_____ _____

Physician Signature Date

EXERCISE READINESS & PRESCRIPTION

PATIENT'S NAME: _____

DOB: _____ **DATE:** _____

PHYSICIAN'S SIGNATURE: _____

Currently Exercising: **Yes** **No**
Type(s) of Activity:
_____

Intensity: _____ _____
(Light, moderate, intense**)**

Duration: _____
(Minutes/session)

Frequency: _____
(Times/week)

PATIENT'S STATE OF CHANGE

Pre-contemplation ☐
(Patient not ready to exercise)

Contemplation ☐
(Patient interested in/beginning to exercise)

Preparation ☐
(Patient's exercise inconsistent/less than optimal)

Action and Maintenance ☐
(Patient exercising recommended amount)

PHYSICAN'S RECOMMENDATIONS

Aerobic Exercise:
_____

Resistance Training/Strength Exercise:
_____

Flexibility Exercise:
_____

Sports Exercise:
_____

Referral to Exercise/Sports Professional:
_____

PHYSICAL ACTIVITY GUIDELINES & RECOMMENDATIONS

Adults aged 18-64 with no chronic conditions: 150 minutes per week of moderate-intensity physical activity through 30 minutes of exercise five days per week. Plus muscle-strengthening activities that involve all major muscle groups performed on 2 or more days per week. **For more information, visit www.acsm.org/physicalactivity.**