Personal Fitness Training
221 First Street East
Mount Vernon, IA 52314
Phone:319-360-2333

Physician's Referral Form

Pertaining to Fitness Evaluation

PLEASE STAMP YOUR OFFICE ADDRESS HERE FOR VERIFICATION

Dear Doctor:

Your patient _____ has contacted me regarding a fitness evaluation. The program is designed to evaluate the individual's fitness status prior to embarking on an exercise program. From this evaluation, an exercise prescription is formulated. In addition, other parameters related to a Health Improvement Program are discussed with the participant. It is important to understand that this program is preventative and is not intended to be rehabilitative in nature.

The fitness testing includes a submaximal five minute bike test, assessment of percent body fat, weight, height, body segment measurements, sit and reach test to evaluate low back and hamstring flexibility, one minute push up test and one minute sit up test to evaluate upper body and core strength and endurance. A comprehensive consultation is provided to the participant, reviewing the test results and explaining recommendations for an individualized program.

A summary of test results and our recommendations will be kept on file and may be made available to you upon request.

In the interest of your patient, for our information, please complete the following:

A. This patient has undergone a physical examination within the last year to assess functional capacity to perform exercise. _____ Yes _____No

B. I consider this patient (Please circle one):

Class I…. presumably healthy without apparent heart disease
Class II… presumably healthy with one or more risk factors for heart disease
Class III.. patient is not eligible for this program

C. Does this patient have any pre-existing medical/orthopedic condition requiring continued or long-term medical treatment or follow-up? _____ Yes _____ No
If yes, please explain: _____
_____

D. Are you aware of any medical condition that this patient may have had that could be worsened by exercise? _____ Yes _____ No
Please explain: _____

E. Does this client have any exercise contraindications? _____ Yes _____ No
If yes, please explain: _____
_____

(CONTINUED)

F. Please list any prescribed medication(s) and any possible side effects that may be worsened with exercise:

_____

_____

Client's name: _____ DOB: _____
Address: _____ Phone: _____

Referring Physician's Signature _____ Date: _____
Additional Comments: _____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize the release of the above requested health and medical information to Transformation Fitness. This authorization is effective for twelve months after the date that it is signed. I understand that I may revoke this authorization at any time by giving written notice to the health care provider or record keeper. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as an original.

_____ _____

Signature of patient Date