# Physician Referral for Client to Exercise

Date faxed:______________________

Patient:______________________________________________ Patient's birth date:______________

Physician:______________________________________________ Physician's phone:______________

Physician's fax:__________________________ Physician's e-mail:__________________________

Dear Doctor,
Your patient has requested to participate in a structured exercise/physical-activity program at
______________________ __________________________. He or she has completed a pre-activity screening as part of his or her enrollment and, as a result of completing that pre-activity screening, has been identified as falling within a risk stratification (moderate-to-high risk) that requires physician clearance prior to engaging in a program of moderate physical activity. The client/patient has approved our forwarding this form to your attention, including the information that has resulted in their being identified as falling into a moderate-to-high risk stratification that requires physician approval before the client can begin participating in a program of moderate physical activity. The classification as moderate-to-high risk is based on the guidelines found in the American College of Sports Medicine's *ACSM's Guidelines for Exercise Testing and Prescription,* 7th edition (2006).

**Coronary Risk Factors**

- ❑ age (male >45, female >55)
- ❑ cigarette smoking
- ❑ elevated BP
- ❑ sedentary
- ❑ elevated blood lipid profile
- ❑ obesity (BMI >30)
- ❑ family history
- ❑ CV disease
- ❑ metabolic disease
- ❑ signs/symptoms
- ❑ pregnancy

Other relevant information: ______________________________________________

______________________________________________________________

______________________________________________________________

Based on the information provided and any other information you, the physician have, your recommendations regarding the patient's participation in a program of moderate physical activity is:

- ❑ Patient/client is not cleared and cannot exercise at this time.
- ❑ Patient/client is cleared and can exercise with no restrictions.
- ❑ Patient/client is cleared with the following restrictions:

Physician's signature: ______________________________________ Date:______________

Please fax back to ____________________ at ______________ within ten (10) days.

P06-036