440 Grove St Worcester, MA 01605
508.852.8209 fax 508.853.6159

Physician Release of Information

Dear Doctor,

Your patient has expressed an interest in participating in a health and wellness program at Worcester Fitness.

Worcester Fitness provides health, fitness and nutritional programs to all populations based on scientific principles. These principles and guidelines have been developed and recommended by the American College of Sports Medicine, and professionals like yourself. The programs are intended to serve as extensions of your patient care.

Our programs are designed to meet a person's individual needs based on an initial assessment of their current health and fitness status. Each member's evaluation includes an overall cardiovascular risk stratification, a resting heart rate and blood pressure screen, a sub maximal aerobic bicycle ergometer test, a body composition measurement, and a flexibility and strength assessment.

Based on our preliminary screening, your patient's medical history indicates a need for your approval prior to engaging in the assessment and subsequent program. Please complete this referral form on the opposite side by listing any contradictions, restrictions, and recommendations you may have. Below is your patient's signature for relevant medical document release, if applicable.

We would be delighted to further inform you about our programs or show our facility. Please feel free to call if you have any questions or concerns.

I, _________________________________agree to the release of medical records to the Worcester Fitness for purposes of evaluations prior to exercise programming, and/or testing.

I understand that you, my physician, will release only the necessary records from my medical files to be used in the evaluation of my health condition so that I may participate in the Worcester Fitness program.

Physician Name____Telephone__________________

Address____

Patient's Signature____Date__________________

Patient Referral Form

Patient diagnosis (if any):____

____

Medications that may affect participation:____

____

( ) Patient cleared to exercise without restrictions.

( ) Patient cleared to exercise with the following guidelines:

Training Heart Rate: ______________bpm

Frequency:______________________times per week

Duration:_______________________minutes

Strength Training: YES NO Limits:__________________________

( ) Patient **NOT** cleared to exercise.

Present and and all other restrictions or limitations to an exercise program:________________

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Suggestions/Comments:____

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Physician Signature____Date________________