Medical Clearance Form

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Email: _____

MRN: _____

REFERRING PHYSICIAN

Physician Name: _____

Department: _____

Phone: _____

Fax: _____

Patient's Primary Health Concerns/Exercise Restrictions:

_____

_____

Recommended exercise intensity: ◯ Light ◯ Moderate ◯ Vigorous

PROGRAMS REFERRAL (CHOOSE ONE)

◯ **Fitness Center Membership:** Patient will be evaluated by an exercise physiologist, who will make class and/or exercise recommendations based on the evaluation.

◯ **Exercise is Medicine® Program:** Patient will be enrolled in an 8-week program that incorporates individualized exercise prescriptions and exercise guidance by an Exercise Physiologist. Exercise treatment will be based on patient's medical diagnosis.

Dx: _____

◯ **Pink Program:** A 12-week holistic, exercise, support, nutrition program for people undergoing treatment for breast cancer or who have completed treatment within the last 12 months.

Dx: _____

Physician Signature: _____

Piedmont Atlanta Fitness Center
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