

Date: \_\_\_\_\_

Dear Doctor \_\_\_\_\_:

Your patient, \_\_\_\_\_ is interested in joining the Wellness Center at Magee Riverfront. Supervision will be provided at the Wellness Center, but no monitoring other than heart rate and blood pressure will be provided. The program will include upper and lower extremity strengthening and aerobic exercise as appropriate.

Patients provide us with a health questionnaire and medication list. To ensure the safety of the participants, we request that you provide us with information that might impact their exercise program.

Please check all that apply in the list below:

- |  |   |
|--|---|
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Spinal cord injury     |
| <input type="checkbox"/> CABG                  | <input type="checkbox"/> Brain injury           |
| <input type="checkbox"/> ICD                   | <input type="checkbox"/> MS                     |
| <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Dementia               |
| <input type="checkbox"/> LVEF <40%             | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Atrial fibrillation   | <input type="checkbox"/> Peripheral neuropathy  |
| <input type="checkbox"/> PAD                   | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Chronic stable angina | <input type="checkbox"/> Hypertension           |
| <input type="checkbox"/> COPD                  | <input type="checkbox"/> Chronic kidney disease |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Anemia                 |
| <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Balance problems       |
| <input type="checkbox"/> Stroke                |   |

Allergies:

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- My patient may participate in the Magee Riverfront Wellness Center Program
- My patient may participate in the Magee Riverfront Wellness Center Program with the following limitations:  
\_\_\_\_\_
- Exercise is contraindicated for my patient

\*\*\* For patients with paralysis. This patient is cleared for standing (please circle):      Yes      No

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return form via fax to 215-218-3925 or by mail to Magee Riverfront, 1500 S. Columbus Blvd, Philadelphia, PA 19147.

If you have any questions, please contact the Wellness Center Staff at 215-218-3900. Thank you.