MAGEE REHABILITATION HOSPITAL

Physician Clearance Form for Magee Riverfront Wellness Center

Date: _____

Dear Doctor _____: Patient Phone #:_____

Patient D.O.B.: _____

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:

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

Allergies:

_____

_____

- ☐ **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.