Clients with MEDICAL CONDITIONS

Medical Program Exercise Prescription

Patient Information

Patient Name: _____ Age: _____ DOB: _____

Patient Phone: _____ Patient Email: _____

Medical Fitness Program (please select one program) *If patient has conditions in 2 programs please select Recovery RX*

□ **Fit RX** (Basic medical conditions. Please check condition)

□ Hypertension □ Type 2 Diabetes □ Osteoarthritis □ Hyperlipidemia

□ Weight Loss (with no comorbidities) □ Healthy Heart □ Other: _____

- ✓ 60-day program
- ✓ Initial fitness assessment with activity plan by exercise professional
- ✓ Meets with exercise professional every other week
- ✓ Provider receives progress report at the end of medical fitness program

□ **Recovery RX** (Conducted by credentialed trainers that focus on functional orthopedic surgery and chronic conditions .)

Pre-Surgery **Post-Surgery**

□ Knee □ Hip □ Ankle □ Elbow □ Wrist

□ Back □ Healthy Heart □ Other: _____

- ✓ 60-day program
- ✓ Initial fitness assessment with activity plan by exercise professional
- ✓ Meets with exercise professional every week
- ✓ Provider receives progress report at the end of medical fitness program

□ **Take Control RX** (Chronic conditions)

□ Parkinson's Disease □ Weight Loss (with at least 1 comorbidity)

□ Other: _____

- ✓ 120-day program
- ✓ Initial fitness assessment with activity plan by exercise professional
- ✓ Meets with exercise professional every other week
- ✓ Provider receives progress report at the end of medical fitness program

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Exercise Prescription May Include

DO	DON'T
□ Cardiovascular Conditioning	□ Cardiovascular Conditioning
□ Mobility Training	□ Mobility Training
□ Strength Training	□ Strength Training
□ Balance and Flexibility	□ Balance and Flexibility
□ Other: _____ _____	□ Other: _____ _____

List any precautions/special conditions for exercise: _____

Healthcare Provider Information

Healthcare Provider Name: _____ Practice Contact (PC) Name: _____

PC Email: _____ PC Fax: _____

Best method to contact the healthcare provider/PC: *(please check any/all that apply)*

□ Call with patient updates/progress report □ Fax with patient updates/progress report

Referring Healthcare Provider Signature: _____ Date: _____

(required)

Provider/Patient Instruction

To get started or for more information, please fax this form to (509) 943-8419 and call (509) 943-8416 and ask for Morgan Fewel.

Must be redeemed within 60 days of prescription date.

1776 Terminal Drive

Richland, WA 99354

phone: (509) 943-8416

fax: (509) 943-8419

morganfewel@my-cbrc.com