

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

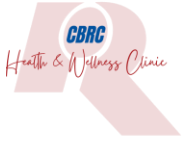
- Knee Hip Ankle Elbow Wrist
- Back Healthy Heart Other: _____

- ✓ 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



Clients with MEDICAL CONDITIONS

Medical Program Exercise Prescription

Exercise Prescription May Include

DO

- Cardiovascular Conditioning
- Mobility Training
- Strength Training
- Balance and Flexibility
- Other: _____

DON'T

- Cardiovascular Conditioning
- Mobility Training
- Strength Training
- Balance and Flexibility
- 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