(478) 353-1900* Phone
(478) 353-1902* Fax

FAIRVIEW FITNESS CENTER

Physician Referral Form

200 Industrial Blvd Building A
Dublin, GA 31021

Patient' Name _____ Age _____ Physician _____

Address _____ Address _____

Phone (H) _____ Phone _____

Dear Doctor:

Your patient is joining a self-guided exercise program at Fairview Fitness Center. This program could involve aerobics, flexibility and weight training. Your patient answered YES to one or more questions on the Par-Q Form and we would like for your to advise us on developing a safe program for your patient. Please assist us by giving your direction in the four areas listed below. Thank you for your time.

Par- Q Findings_____

_____

_____

PLEASE ADVISE ON EACH SECTION

1) Stress Test Evaluation:

___ NO. Patient does not need a stress test.

____ YES. Patient does need a stress test. (It is patient/physician's responsibility to schedule stress test and bring copy of findings to Fitness center to place in member's medical history file.)

2) Exercise Intensity:

____ 70-80% Maximal Heart Rate

____ Perceived Exertion (Patient on cardiosuppressive medications)

____ Other Heart Rate Intensity (Please specify: _____)

3) Check methods of training to avoid:

____ No restrictions ____ Flexibility ____ StairMaster ____ Running/Jogging

____ Free weights ____ Rowing Machine ____ Aerobics Classes ____ Nautilus Equipment

____ Racquetball ____ Elliptical ____ Swimming ____ Walking/Treadmill

____ Other: _____

4) Diet Instructions

____ Basic Nutritional ____ Weight Reduction ____ Low Cholesterol

____ Low Sodium ____ Low Triglycerides ____ Other: _____

Please list any special comments, instruction, precautions or restrictions regarding this client's participation in an exercise program:_____

_____

_____ _____

Physician's Signature Date