Physician Medical Clearance for Physical Activity/Exercise

Patient Name: _____

Birth date: _____ Gender: □ Male □ Female

Dear Dr. _____:

Your patient has participated in a health screening and has given permission to share this information.

_____ qualifies for membership to Labette Health's *The CORE* Medical-Based Fitness program based on one or more of the following risk factors:

☐ Cholesterol (total cholesterol greater than 200 mg/dL)

☐ Glucose (greater than 200 mg/dL)

☐ Triglycerides (greater than 150 mg/dL)

☐ Hypertension (systolic BP greater than 140 mmHg, diastolic BP greater than 90 mmHg confirmed by 2 measures)

☐ Obesity (body mass index greater than 30)

☐ Overweight (body mass index between 25.0 at 29.9)

☐ Sedentary lifestyle (person does not participate in a regular exercise program)

☐ Family history (history of heart attack or heart surgery before age 55 on male side of the family; 65 on female side)

☐ Cigarette smoking (current or stopped within last 6 months)

☐ Physical Therapy transition patient (> 6 patient visits with therapist)

Your patient, _____, seeks to participate in Labette Health's Medical-Based Fitness Program, and will, at minimum, receive orientation to the available physical activity/exercise equipment. Your patient will receive an initial session with the Medical-Based Fitness Manager who will assist your patient in developing personalized goals to decrease his/her overall health risk factors. It is the responsibility of your patient to share any additional information regarding additional measures of their medical fitness program.

Please check on of the following statements:

_____ I concur with my patient's participation in the Program with no restrictions.

_____ I concur with my patient's participation in the Program if he/she restricts activities as follows:

_____

_____ I do not concur with my patient's participation in the Program

_____ _____

Provider's Name (print) Provider's Signature Date

Phone: (620) 820-5910 Fax: (620) 820-5140

Authorization for Release of Protected Health Information

I, _____, hereby authorize ***Labette Health Rehab Services' The Center of Rehabilitation Excellence***, the following information:

Pre-activity Health Screening Results (including lab measures), Health History Inventory, and list of health risk factors.

and forward it to the following person/facility:

Name of Person or Facility: _____

Address (street, city, state, zip code):

Phone: _____

This information is for the purpose of ***sharing health risk factors and obtaining physician medical clearance to participate in a medical based fitness program.***

This authorization is in effect until _____, when it expires (Can be no later than 1-year from the date of the Authorization per K.S.A. 65-4970).

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that authorization is voluntary.
- I understand the notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand that if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE: _____ DATE**:** _____