Medical Clearance Form

Date:

Client's Name:

Client's Phone:

Client's DOB:

Physician* Name:

Physician Phone:

Physician Fax:

Dear _____,

Your patient _____has requested to participate in **Total HealthWorks' Total Parkinson's**: An exercise program for those with Parkinson's Disease. At the start of this program your patient will participate in a fitness assessment, which may include the 6-minute walk test, strength testing for upper and lower body, balance and flexibility testing, or another assessment administered by a qualified individual. Following the fitness assessment, your patient will partake in cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance activities. A specific, individualized exercise program may be created for the participant based on the needs, interests and any recommendations you might have. The **Total Parkinson's** program is designed to start easy and become progressively more difficult over a 12-week period. All fitness assessments and exercise activities will be administered by qualified personnel trained in conducting exercise tests and exercise programs.

Based on the **Total Parkinson's** intake form, your patient has indicated a diagnosed medical condition and/or health condition that require a physician's clearance prior to participation in the **Total Parkinson's** program.

By completing the form below, you are not assuming any responsibility for our administration of the fitness assessment or exercise program. If you know of any medical or other reasons why participation in the **Total Parkinson's** would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the **Total Parkinson's**, please call or email the program coordinator listed below. Thank you.

Program Coordinator: Shashu Baraka, 269-459-4856 or sbaraka@kzooymca.org. **Fax: 269-459-4873**

Physician Report

My patient, listed above, is:

_____Not cleared to exercise at this time _____Cleared to exercise with no restrictions

_____Cleared to exercise with the following restrictions and/or recommendations below:

_____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

*You may need medical clearance from more than one physician. E.g. neurology, primary care.