Griffin Hospital Weight Management Exercise Referral Form

Referral Date ____________

Patient's name ______________________________ Date of Birth ________________

Address ____

Phone Number ______________________________

Your patient would like to begin a moderate exercise program at the Griffin Hospital Fitness Center, located in the Hewitt Pavilion on Seymour Avenue. Aerobic, flexibility, and muscular condition exercises will be individually prescribed and practiced in our supervised Fitness Center, following the guidelines of the American College of Sports Medicine and the American Heart Association.

Complete the following <u>or send a current office note</u> to include the following:

Medical Conditions

_____ **Diabetes**
_____ **Stroke**
_____ **Hypertension**
_____ **Hypercholesterolemia**
_____ **History of Cancer – Type:** ________________
_____ **Heart Disease – DX** ________________
_____ **Smokes – Amount per day** __________
_____ **Pulmonary or Breathing Problems**
_____ **Orthopedic Problems Explain:** ______________
_____ **Arthritis**

Additional pertinent Medical History: ____

____

Please list any restrictions: ____

Current Medications and doses: ____

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I give the above named patient my approval to begin exercising at the Griffin Hospital Fitness Center, with the recommendations and/or restrictions as listed above.

X______________________________ **Date** ____________________

(Physician's Signature)

Physician's Name (please print)

____

Address

____

City, State

____

Phone Number

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