GRIFFIN HEALTH

Griffin Hospital Exercise Referral & Release Form

Date _____

Your patient would like to begin a moderate-intensity exercise program at Griffin Health. Please see the checked off program that your patient is currently looking to participate in, below:

By completing the attached exercise release, **I acknowledge and approve that this exercise release can be used for any of the following exercise programs offered at Griffin Health.**

☐ **GlucoseZone Exercise Program for Pre-Diabetes & Diabetes:** a moderate-intensity 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. Basic education regarding goal setting, stress reduction, nutrition and overcoming obstacles will be offered in educational sessions.

Program Office Phone: (203) 732-1369 Fax Number: (203) 732-3319

☒ **Weight Management Exercise Program:** a moderate-intensity 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.

Program Office Phone: (203) 732-7106 Fax Number: (203) 732-1418

☐ **Wellness for Life Program:** a lifestyle modification and chronic disease management program that will include a moderate-intensity exercise program at the Griffin Hospital Quarry Walk Center, located in Oxford, CT. Aerobic, flexibility and resistance training 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. Education regarding goal setting, stress reduction, nutrition and overcoming obstacles will be offered in educational sessions.

Program Office Phone: (203) 732-1369 Fax Number: (203) 732-3319

GRIFFIN HEALTH

Griffin Hospital Exercise Referral & Release Form

Date _____

Patient's name _____ Date of Birth _____
Address _____
Phone Number _____

Complete the following or send a current office note that includes the following:

Date: _____ ***Weight:*** _____ ***BP:*** _____/_____ ***HbgA1c:*** _____

Medical Conditions

_____ Prediabetes
_____ Diabetes
_____ Stroke (CVA)
_____ 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: _____
_____
_____
_____

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)

Please print provider information below:

Physician's Name
_____
Address
_____
City, State
_____
Phone Number
_____

Please return fax to:

Cardiac Rehabilitation
Phone: (203) 732-7106
Fax: (203) 732-1418