Physician Medical Release Form
TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: _____/_____/_____

Patient _____

Phone #: (_____) _____

DOB _____/_____/_____

(Patient name)_____wishes to participate in the Enrich Community Neurorehabilitation Program for people with neurological conditions. Our goal is to help your patient have a better quality of life through fitness and socialization. The activities may involve cardiovascular training, flexibility instruction (stretching, getting up and down on the floor), resistance training, core strengthening, balance and coordination training, and task-oriented movement training. Safety and modifications for various levels of fitness, mobility and disease progression are considered.

Diagnosed Neurological Condition: _____

Date of Onset of Condition: _____

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on heart rate response during exercise:

Type of medication _____ Effect _____

Type of medication _____ Effect _____

Type of medication _____ Effect _____

PHYSICIAN'S RECOMMENDATION

☐ I am not aware of any restrictions to participate in this exercise program.

☐ I believe the patient can participate but would urge caution (*please explain*): _____

_____

☐ Patient should not engage in the following activities: _____

_____

PHYSICIAN COMPLETES

_____ (**patient's name) has my approval to begin the Enrich Community Neurorehabilitation Program with the recommendations or restrictions stated above.**

Printed name _____ **Phone** _____

Signature _____

RETURN TO
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