

PATIENTS:

Please print the information in this section, sign and give this form to your physician.

LAST NAME (print) \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ CIRCLE: **M** **F** PHONE # \_\_\_\_\_

PRESCRIBING PHYSICIAN (print) \_\_\_\_\_ PHYSICIAN PHONE # \_\_\_\_\_

I give my prescribing physician permission to share the following health information with HealthPlex representatives.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

REFERRING PHYSICIANS:

Please check the appropriate box, write in the patient's diagnosis, sign, and return this form to the patient or fax it to the HealthPlex at (618) 526-1430. If you have any questions, call the HealthPlex at 618-526-5628. Should you want to refer additional patients for general exercise, forms can be downloaded at [www.stjoebreese.com](http://www.stjoebreese.com) or call and we will mail you a packet. Thank you!

American College of Sports Medicine recommendations:

- 1) Asymptomatic, apparently healthy, men under age 40 and women under age 50, with fewer than 2 coronary disease risk factors, do not require medical evaluation by a physician before initiating a program of vigorous exercise (>60% VO2max).
- 2) Other individuals should be screened medically with stress testing of an appropriate manner.

Should you desire, we offer exercise evaluations/consultation and testing through David Neighbors, MD, at Competitive Edge Sports Medicine located in the HealthPlex Clinic.

- I approve of my patient's participation in an exercise program at St. Joseph's Hospital HealthPlex.
- I approve of my patient's participation in an exercise program at St. Joseph's Hospital HealthPlex with the following restrictions:

\_\_\_\_\_  
\_\_\_\_\_

- I wish for my patient to have a medical clearance consultation done by Dr. David Neighbors.
- I do not approve of my patient participating in an exercise program for the following reason:

\_\_\_\_\_  
\_\_\_\_\_

Please provide the patient's diagnosis so that we may place them in the proper exercise program:

DIAGNOSIS \_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ ADMIN INITIALS \_\_\_\_\_