SEMPER FIT PHYSICAL FITNESS

PARmed-X

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From: _____ Date:_____

Dear Dr. _____

Your patient, _____, wishes to participate in a physical fitness assessment and subsequent exercise program at the Barber Physical Activity Center.

The physical fitness assessment will consist of the following measurements: resting heart rate and blood pressure, body fat, bicep strength, flexibility and cardiorespiratory fitness. An exercise program, which may involve flexibility, cardiovascular and/or resistance training exercises, will be developed based on the fitness assessment results.

Please review and complete the bottom portion of this form in regards to your patient's eligibility in participating in the Semper Fit program. This PARmed-X and release form will be maintained in a confidential manner and disclosed only to the patient and representatives of the Semper Fit Physical Fitness Staff. If you have any questions, please feel free to contact me at (703)432-0593. You may fax this form back to me at 703-432-0588.

Thank you,

This section to be completed by the participant

PERSONAL INFORMATION

NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

BIRTHDATE: _____

GENDER: _____

PAR-Q: Please indicate the PAR-Q questions to which you answered YES

- ☐ Heart condition
- ☐ Chest Pain during activity or rest
- ☐ Loss of balance, dizziness
- ☐ Bone or joint problem
- ☐ Blood pressure or heart drugs
- ☐ Other reason:

_____

RISK FACTORS FOR CARDIOVASCULAR DISEASE:

Check all that apply:

- ☐ Less than 30 minutes of moderate physical activity most days of the week.
- ☐ Currently smoker (tobacco smoking 1 or more times per week).
- ☐ High blood pressure reported
- ☐ High cholesterol level reported by physician
- ☐ Excessive accumulation of fat around waist
- ☐ Family history of heart disease

Please note: *Many of these risk factors are modifiable. Please discuss with your physician.*

PHYSICAL ACTIVITY INTENTIONS:

What physical activity do you intend to do?

_____

_____

_____

This section to be completed by the examining physician

Physical Exam:

HT	WT	BP 1 /
		BP 2 /

Conditions limiting physical activity:

Test required:

- ☐ Cardiovascular — ☐ ECG
- ☐ Musculoskeletal — ☐ Blood
- ☐ Respiratory — ☐ Exercise Test
- ☐ Abdominal — ☐ Urinalysis
- ☐ Pregnancy — ☐ X-Ray
- ☐ Other _____ — ☐ Other

Pregnancy: Absolute/Relative Contraindications

	Yes	No
1. Ruptured membranes, premature labour?	☐	☐
2. Persistent second or third trimester bleeding/placenta previa?	☐	☐
3. Pregnancy induced hypertension or pre-eclampsia?	☐	☐
4. Incompetent cervix?	☐	☐
5. Evidence of intrauterine growth restrictions?	☐	☐
6. High-order pregnancy(e.g., triplets)?	☐	☐
8. History of spontaneous abortion in previous pregnancies?	☐	☐
9. Anemia or iron deficiency?	☐	☐
10. Malnutrition or eating disorder?	☐	☐
11. Twin pregnancy after 28th week?	☐	☐
12. Other significant medical condition?	☐	☐

PARmed-X Physical Activity Readiness Convey/Referral Form

Based upon a current review of the health status of _____, I recommend:

- ☐ No physical activity
- ☐ Only a medically-supervised exercise program until further medical clearance
- ☐ Progressive physical activity
  - ☐ with avoidance of: _____
  - ☐ with inclusion of: _____
  - ☐ under the direct supervision of a Semper Fit Personal Trainer
- ☐ Unrestricted physical activity

Further Information:

- ☐ Attached
- ☐ To be forwarded
- ☐ Available on request

Additional comments you feel appropriate for your patient in regards to a fitness assessment and subsequent exercise program:

_____

_____

_____

M.D.

_____ 20_____

(date)

***NOTE: This physical activity clearance is valid for a maximum of six months from the date it is completed and becomes invalid if your medical condition becomes worse.

Physician/clinic stamp: This record must be stamped or accompanied with a typed letter on the physician's letterhead