

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
**Class:** \_\_\_\_\_ **Date Of Birth:** \_\_\_\_\_

*Best time(s) and phone number(s) to reach me at for a pre-participation interview (a 15 - 30 minute phone conversation with Sports Medicine staff).*

1. \_\_\_\_\_ AM PM \_\_\_\_\_ H W  
DAY(S) TIME PHONE # DAY(S) TIME PHONE #

# Physician's Authorization Form

The above named patient is interested in participating in an exercise program at the UW Health Sports Medicine Fitness Center. Prior to participating new members must acquire authorization from their physician. Please complete this form as thoroughly as possible for this patient.

PHYSICIAN COMPLETES  
Forms missing information (incomplete sections) will be returned for completion prior to client's participation.

## 1 Medical History (check and specify all applicable)

- Heart Disease (MI, CABG, PTCA, etc.) \_\_\_\_\_
- Diabetes Mellitus \_\_\_\_\_
- Neurologic Disorder \_\_\_\_\_
- Stroke \_\_\_\_\_
- Peripheral Arterial Disease \_\_\_\_\_

## 2 Risk Factors (check and specify all applicable)

*It is our policy to recommend a graded exercise tolerance test (ETT) for men over the age of 40 and women over 50 who have 2 or more of the following risk factors who are BEGINNING a VIGOROUS exercise program.*

- Diagnosed Hypertension  
*Resting SBP > 160 OR Resting DBP > 90 OR taking any hypertensive medications*
- Obesity
- Hyperlipidemia  
*Total Cholesterol = \_\_\_\_\_ HDL = \_\_\_\_\_  
TChol/HDL Ratio = \_\_\_\_\_*
- Cigarette Smoking
- Diabetes (Type I or II)
- Family history of coronary or atherosclerotic disease (parents/siblings) prior to age 55
- Inactivity or Sedentary Lifestyle

## 3 Screening Choices (select one)

- A graded exercise tolerance test is not indicated for this patient.
- I have performed a graded exercise tolerance test and have enclosed a copy of the test results.
- I would like my patient to receive a graded exercise tolerance test through the UW Health Preventive Cardiology Department before participating in an exercise class (test fee not included in class fee).
- I would like my patient to participate in a monitored exercise session before participating in a class (test fee: not included in class fee). This session includes a submaximal test with bipolar single lead ECG, hemodynamics and symptom monitoring.

## 4 Patient Limitations/Restrictions

*Specify*  
 \_\_\_\_\_  
 \_\_\_\_\_

- No restrictions or limitations for this patient.
- I would like to speak with the exercise coordinator prior to my patient participating in any exercise program. Please call me at the below number.

## 5 Physician Signature

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 PRINT Physician Name: \_\_\_\_\_  
 Clinic Name & Address: \_\_\_\_\_ Phone: \_\_\_\_\_