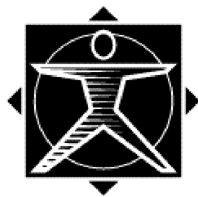
Name: ______________________ **Phone #:** ___________ **Date Of Birth:** __________

UW HEALTH SPORTS MEDICINE FITNESS CENTER (608) 263–7936



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. **Forms missing information (incomplete sections) will be returned for completion prior to participation.**

I. Medical History (check and specify all applicable)

- ☐ Heart Disease (MI, PTCA, CABG, etc.) ______________________
- ☐ Diabetes Mellitus ______________________
- ☐ Neurological Disorder ______________________
- ☐ Stroke ______________________
- ☐ Peripheral Arterial Disease ______________________

II. 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 antihypertensive medication
- ☐ Hyperlipidemia
  Total Cholesterol = ______ *HDL =* ______ *TChol/HDL Ratio =* ______
- ☐ Diabetes *(Type I or II)*
- ☐ Obesity
- ☐ Cigarette Smoking
- ☐ Family history of coronary or atherosclerotic disease (parents/siblings prior to age 55)
- ☐ Inactivity or Sedentary Lifestyle

III. 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 Preventive Cardiology Program before participating in an exercise program. (This test is not included in the program fee).

IV. 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.

V. Physician's Authorization

Physician's Signature: ______________________ Date: __________

PRINT Physician Name: ______________________

Clinic Name & Address: ______________________ Phone: __________

- -

Mail, FAX (608-263-2215) Attn: **FC Staff** completed form to

UW Sports Medicine Fitness Center *621 Science Drive* *Madison, WI 53711*
(608) 263-7936