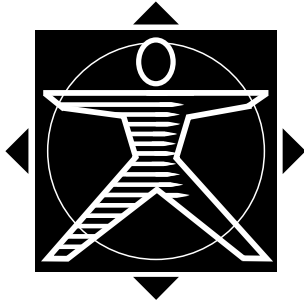


Name: _____

Phone #: _____

Date of Birth: ____ / ____ / ____



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, a new member must acquire authorization from his or her Primary Care Provider (PCP). Please complete this form as thoroughly as possible for this patient. **Forms missing information (incomplete sections) will be returned for completion**

1 Medical History (check and specify all applicable)

- Heart Disease (MI, CABG, PTCA, etc.) _____
- Diabetes Mellitus (Type I or II) _____
- Neurologic Disorder _____
- Stroke _____
- Peripheral Arterial Disease _____

2 Risk Factors (check and specify all applicable)

- Diagnosed Hypertension
Resting SBP > 140 OR Resting DBP > 90 OR taking any hypertensive medications
- Diabetes (Type I or II)
- Cigarette Smoking
- Dyslipidemia
*Total Cholesterol = ____ HDL = ____
TChol/HDL Ratio = ____*
- Family history of coronary or atherosclerotic disease (parents/siblings) prior to age 55

3 Patient Limitations/Restrictions/Information

Specify

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

4 Physician Signature

Physician Signature: _____ Date: _____

PRINT Physician Name: _____

Clinic Name & Address: _____ Phone: _____

FAX, mail or deliver completed form to: