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
- ☐ Dyslipidemia
  Total Cholesterol = ____ *HDL =* ____
  TChol/HDL Ratio = ____
- ☐ Diabetes (Type I or II)
- ☐ Cigarette Smoking
- ☐ 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:

UW Health Sports Medicine

F A X **263-2215** *Attn:* Fitness Center

621 Science Drive
Madison, WI 53711
(608) 263-7936