



## MEDICAL CLEARANCE FORM TO BE COMPLETED BY PHYSICIAN

Client safety is our primary concern. A completed medical release is required to initiate Pushing Boundaries' exercise therapy evaluation process. **This document must be completed by the client's physician and returned to Pushing Boundaries.**

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*Pushing Boundaries provides intensive, repetitive, and restorative therapy for the purpose of regaining and maintaining function. Duration of sessions are 1-3 hours in length, 1-5 times per week. Criteria to participate include (but are not limited to) cognition, cardiovascular capacity, bone density, and overall safety of participating in an intensive exercise therapy-based program. **We do not provide Physical Therapy.***

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Client Diagnosis (list all, including incomplete vs. complete, level, affected side, etc.):

\_\_\_\_\_  
\_\_\_\_\_

**Has client had a bone density scan in the last 12 months?** (note- client will be unable to use some equipment where osteoporosis is a contraindication if they have not had a bone density scan in the last 12 months)

Yes \_\_\_\_\_ No \_\_\_\_\_ Client was diagnosed less than 12 months ago \_\_\_\_\_

### Results?

Severe Osteoporosis \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Osteopenia \_\_\_\_\_ Normal \_\_\_\_\_

Other comments:

\_\_\_\_\_

***Please Check any Programs APPROVED for Client to Participate In:***

\_\_\_ Flexibility

\_\_\_ Balance

\_\_\_ Cardio

\_\_\_ Overground Gait Training (with gait belt, device, and or trainer support – describe any restrictions in next section)

\_\_\_ Vibration Therapy\*

\_\_\_ Full Weight Bearing

\_\_\_ Supported Weight Bearing (harness, trainer, tilt table, or other device supported – describe any restrictions in next section)

\_\_\_ Core Strengthening

\_\_\_ Functional Electrical Stimulation\*

\*explanation of equipment attached

\_\_\_ Robotic Gait Training\*



Other Comments/Restrictions/clearances:

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***Please Circle One:***

Is client at increased risk for Low Blood Pressure (Hypotension)? **YES / NO**

Is client at increased risk for High Blood Pressure (Autonomic Dysreflexia)? **YES / NO**

Does client have any implanted devices (Pacemaker, etc.)? **YES / NO**

Please Explain:

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Is there anything else we should be concerned about? **YES / NO**

Please Explain:

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Physician's Name (Please Print):

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Physician Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Email: \_\_\_\_\_

Address:

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Physician Signature:

Date:

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## ***Absolute and Relative Contraindications for Specialized Equipment***

*\*Please note, this list is for informational purposes only and is not an exhaustive list of equipment risks and contraindications. All equipment on site and all forms of exercise has its potential risks, including and up to death.*

*Any client may be excluded from using a particular piece of equipment at the discretion of Pushing Boundaries, regardless of physician sign off.*

### **Functional Electrical Stimulation (FES)**



#### **RT-300 (FES U/E and L/E cycle)**

Contraindications – Implanted pacemakers, unhealed fractures in active limb, pregnancy, (U/E only – grade 3 tear or greater in rotator cuff, uncorrectable subluxation)

Risk factors– Skin wounds, high spasticity, uncontrolled BP, severe osteoporosis, pressure sores or open wounds, malignant tumors, plates. Pins and other hardware must have been placed 3 months prior to use.



#### **Bioness (FES calf and thigh cuff)**

Contraindications – Unhealed fractures in active limb, present or suspected cancerous lesion, electric and metallic implants (internal pacemakers or defibrillators).

Risk factors – Sensitivity to pain, hypersensitivity, poor skin integrity, caution with known epilepsy and cardiac conditions.

### **Robotic Gait Training**



#### **Lokomat (over treadmill robotic gait training)**

Contraindications – Unhealed fractures, osteoporosis, fixed joint contractures, weight over 297lbs, pregnancy, uncorrectable leg length differences, unprotectable skin lesions, any other reason or condition that prevents proper fit of harness or orthotics.

Risk factors – uncontrolled joint instability, lack of head control, sensory impairment, uncontrolled blood pressure, elevated risk of seizures, cardiac instability, mechanical ventilation, long term infusions, pumps, or stimulators, high spasticity, uncooperative or aggressive behavior.



### **Indego (over ground robotic gait training)**

**Contraindications** – Unhealed fractures, deep vein thrombosis, uncorrectable leg length difference, osteoporosis, pregnancy, hip, or knee contractures greater than 10 degrees or ankle contractures greater than 5 degrees, cognitive impairments resulting in inability to follow directions, Psychiatric conditions that interfere with operation, any other concurrent or unresolved condition preventing proper use of device, or inability to fit parameters of the device.

**Risk Factors** - Colostomy bag, high spasticity, poor skin integrity, hypotension, having increased risk for autonomic dysreflexia.

## **Vibration Therapy**

### **Galileo Vibration Plate**



**Contraindications** – Artificial joints, Epilepsy, Acute thrombosis, Acute inflammation, acute hernia, acute discopathy, unhealed fractures in activated region, gallstones/stones in UTI tract, incomplete wounds in activated regions, rheumatoid arthritis.

**Risk factors:** uncontrolled blood pressure, poor skin integrity.