Exercise Therapy Medical Clearance

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.

Client Name: _____ Physician Phone: _____

Physician Name: _____ Physician Fax: _____

Physician Address: _____

I hereby grant my physician permission to release any pertinent medical information from any medical records to Pushing Boundaries. All information will be kept confidential.

_____

Client/Representative Signature *Date:*

For Physician Use Only

Exercise Therapy *is a regimen of full body physical activities designed and prescribed for specific therapeutic goals to restore musculoskeletal function, increase strength, endurance, range of motion, or to reduce pain caused by diseases or injuries to increase independence. Activities may include active/passive/FES cycling, full body weight standing and gait training, resistive exercise, mat/floor work, body-weight-supported treadmill training, vibration therapy and cardio. Please contact us if you have any questions about the services we provide.*

Pushing Boundaries provides intensive, repetitive, and restorative therapy for the purpose of regaining function. Duration of sessions are 2-3 hours in length occurring several 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.***

☐ This patient has medical clearance to participate in exercise therapy without restriction.
☐ This patient has medical clearance to participate in exercise therapy with the following restriction(s):

☐ This patient is not cleared for exercise therapy for the following reason(s):

Is it safe for this patient to bear weight in a standing frame? ☐ Yes ☐ No

Prescribed Medications that may affect Blood Pressure or Balance: _____

Medical Precautions or Recommendations: _____

Quality of Patient's Pulmonary Health: _____

I would like to see my patient focus on the following:

☐ Balance ☐ Coordination ☐ Strength Training
☐ Gait Mechanics ☐ Conditioning ☐ Flexibility/ROM
☐ Other: _____

Additional Comments: _____

_____

Physician Signature *Date:*