new U Fit Beginnings
A Physician Referral Program Focusing On Exercise

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Attention
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Medical referral form

From the office of _____
Referring healthcare professional

Patient information:

Name _____

Phone number _____

Email address _____

Birthday _____

Please check one of the following:

❑ Patient is cleared **for water exercise ONLY.**

❑ Patient is cleared for unsupervised exercise.

❑ Patient is cleared for exercise under the following conditions:

_____

_____

_____

Recommended exercise prescription: (check all that apply or leave up to CA's Fitness Specialist)

❑ Cardiovascular conditioning ❑ Lose weight ❑ Strength training

❑ Improve flexibility ❑ Nutrition counseling ❑ Aquatic exercise

❑ Progressive increase in training at the discretion of trainer

❑ Do not exceed age predicated maximum heart rate (MPHR)

❑ Increase duration and intensity of workout ____every session ____each week ____every 2 weeks

❑ Other _____

_____

Healthcare professional signature **Date**

Columbia Association