Rx PROGRAMS

EXERCISE PRESCRIPTION

Date _____

PATIENT INFORMATION

Name _____
D.O.B. _____
Phone _____
Email _____

1. Please mark **ALL** appropriate conditions.
2. Please mark **ONE PROGRAM** (if a patient has conditions in both programs, mark "**PROGRAM 2**".

O PROGRAM 1: Fit Rx *(basic medical conditions)*:

Hypertension — Type 2 Diabetes
Osteoarthritis — Hyperlipidemia
Weight loss (with no comorbidities)
Other: _____

O PROGRAM 2: Recovery Rx *(conducted by credentialed trainers that focus on functional orthopedic surgery and chronic conditions)*:

SURGERY:

Pre-surgery		**Post-surgery**
Knee	Hip	Ankle
Elbow	Wrist	Back

Other: _____

CHRONIC CONDITION:

Parkinson's disease
Weight loss (with at least 1 comorbidity)

Exercise prescription may include:

DO DON'T

Cardiovascular Conditioning
Strength Training
Balance and Flexibility
Mobility Training

**ACSM guidelines followed unless otherwise noted/ prescribed.*

List any precautions/special conditions for exercise:

_____

_____

PHYSICIAN/CLINICIAN INFORMATION

Physician/Clinician Name

_____

Practice Contact (PC) Name

_____

PC Phone _____
PC Email _____
PC Fax _____

BEST METHOD TO CONTACT THE PHYSICIAN/CLINICIAN

Please check any/all that apply:

Call with patient updates/progress reports.
Email patient updates/progress reports.
Fax patient updates/progress reports.
EPIC patient updates/progress reports.

Provider License Number/State

_____

Physician's Signature ***(Required)***

_____

PATIENT INSTRUCTION

To get started or for more information, please call 853-0000.

It must be redeemed by _____
(60 days from today).

CARILION Wellness