NOAA WELLNESS & FITNESS CENTER
1315 EASTWEST HIGHWAY RM M2455
SILVER SPRING, MD 20910
PHONE: (301)713-0473 FAX: (301)713-0475

PHYSICIAN'S REFERRAL FORM

Dear Dr.

Your patient _____ would like to begin an exercise program at The NOAA Fitness Center. After reviewing his/her responses to our Health History questionnaire, we would appreciate your medical opinion and recommendations concerning his/her participation in an exercise program. Please provide the following information and return this form back to us by faxing it to (301)713-0475.

1. Please specify any concerns or conditions our staff should be aware of which are pertinent to this individual:

____Heart Disease	____Claudication
____Hypertension (>140/90 mm Hg)	____Syncope
____High Cholesterol (>240 mg/ dL)	____Significant Musculoskeletal Disorders
____Diabetes or Hypoglycemia	____Pregnancy
____COPD	____CABG
____Other	

If checked, please specify _____

2. Has this individual completed an exercise test? Yes/No
   a. Date of test _____. Please provide a copy of it and interpretation.
   b. Your specific recommendations for exercise training, including heart rate limits during exercise: _____

*If an exercise test **has not** been performed please see attached waiver and sign.

3. Is this patient taking any medications which could have an effect on an exercise program?
   Yes/No
   Please List:

4. Please provide the following information so that we may contact you if we have any further questions:
   ____ I **AGREE** to the participation of this individual in an exercise program at your fitness center, finding no contraindications.
   ____ I **AGREE** to the participation of this individual in an exercise program at your fitness center, however, participation is advised with the following constraints:

   ____ I **DO NOT AGREE** that this individual is a candidate to exercise at your fitness center because _____

Physician's Signature: _____
Physician's Name: _____
Address: _____
Phone: _____ Fax: _____

Thank you for your help.