the works wellness center

Please complete and fax to The Works Attn: Carrie Richer (603) 609-6306

Patient's Name:

Address:

D.O.B

Phone Number:

Physician Office:

Referring Physician:

Reason for Referral/Diagnosis:

Please complete this medical clearance so that the patient named above may engage in the specified wellness program below at The Works Health and Fitness Center.

Please check the box for which wellness program you are referring to

☐	☐	☐	☐
WORKS RX *functional movement program * core stabtility & balance *breakdown barriers to exercise **Circle if applicable:**	**WEIGHT MANAGEMENT** *individual setting, long term *comprehensive team approach with RDs, Health Coaches, & Behavioral Health Specialists *nutrition, exercise, behavior change **CRITERIA: BMI ≥30 or Waist ≥35 female ≥40 Male**	**PREVENTION THROUGH NUTRITION** * guidance in nutrition for disease prevention and weight management	**HEALTHY CARE 90 DAY** *group setting * education on fitness, nutrition, stress management, and behavior modification
Post PT	***Most recent H & P needed***	***Most recent H &P needed***	***Most recent H & P needed***
Post Cardiac Rehab	***& copy of insurance card***	***& copy of insurance card***	***& copy of insurance card***

Please check the appropriate situation for the patient named above.

_____ YES the patient named above is cleared to participate in all forms of exercise

Limitations/Contraindications: _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____