



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

Patient's Name:

Physician Office:

Address:

Referring Physician:

D.O.B

Phone Number:

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 stability & balance  
 \*breakdown barriers to exercise

**WEIGHT MANAGEMENT**  
 \*individual setting, long term  
 \*comprehensive team approach with RDs, Health Coaches, & Behavioral Health Specialists  
 \*nutrition, exercise, behavior change  
  
**CRITERIA: BMI  $\geq$ 30 or  
 Waist  $\geq$ 35 female  $\geq$ 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

*Most recent H & P needed  
 & copy of insurance card*

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By providing the information above, I authorize my health care practitioner to disclose pertinent medical information including medical records for the purpose of determining my eligibility for Wellness Programs and conducting other activities as permitted by law. \_\_\_\_\_ initials

*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: \_\_\_\_\_

# Fax Cover Sheet

## The Works Health & Fitness Center

23 Works Way  
Somersworth, NH 03878

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<b>From:</b>	<b>Works Phone #</b>	<b>603-742-2163 x731</b>
Wellness Center		
<b>To:</b>	<b>Works Fax #</b>	<b>603-609-6306</b>
<b>Fax:</b>	<b>Number of pages:</b>	

MESSAGE: