the works wellness center

Please complete and fax to The Works Attn: Wellness (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**	☐ **WEIGHT MANAGEMENT**	☐ **PREVENTION THROUGH NUTRITION**	☐ **OSTEOPOROSIS PREVENTION**
*functional movement program * core stabtility & balance *breakdown barriers to exercise	*individual or group setting *comprehensive team approach with RDs, Health Coaches, & Behavioral Health Specialists *nutrition, exercise, behavior change	* guidance in nutrition for disease prevention and weight management	*group setting * education on fitness, nutrition, stress management, and behavior modification

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. _____ inititals

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:** _____