

P.R.E.P.

physician referred ~~X~~ exercise program

Patient is cleared for unsupervised exercise.

Please list any precautions/special conditions for exercise clearance:

Optional

(Please check any/all that apply)

- Cardiovascular exercise
- Strength training
- Aquatic exercise

Patient Information

Patient name _____

Patient phone _____

Birthdate ___/___/___

Physician Information

Physician name _____

Physician signature _____

Date ___/___/___

Practice mailing address:

Contact

Fax this form or call ACAC's
Coordinator of Medical Programs.

(804) 378.1600 phone

(804) 794.8160 fax

Method of Contact

(Please check any/all that apply)

- Mail** me patient updates/progress reports
- Call** with patient updates/progress reports
- Email** patient updates/progress reports
- Please advise me if patient does not pursue program
- I do not require follow-up on this particular patient at this time

Physician Stamp