Trinity Health Of New England | Mount Sinai Rehabilitation Hospital Fitness and Wellness Programs

Fitness and Aquatic Center
490 Blue Hills Ave.
Hartford, CT 06112
Phone: 860-714-3069
Fax : 860-714-8550

Physician Release Form

Your Patient,_____, DOB:_____
Is interested in participating in the following programs at Mount Sinai Rehabilitation Hospital Fitness and Aquatic Center. Please complete and sign this foam and fax it to the number above.

- **Exercise Program,** Custom designed supervised exercise program. Program will consist of cardiovascular exercise/resistance training.
- **Individual Walking Program,** Fitness members who require one-on-one assistance to walk may schedule to walk with a member of the fitness staff. Individual may walk for 30 minutes
- **Aquatic Arthritis Program,** This recreational aquatic program is specifically designed for arthritis patients, who are limited by joint pain and/or strength. Class is done in a warm (94 degrees) pain free environment.
- **Graduate Aquatic Program,** This one hour exercise program allows patients to work on their exercises independently in a warm (94 degree) environment.
- **Aquatic Back Program,** This class is designed to strengthen your "core", increase your flexibility, improve your posture and enhance body mechanics.
- **Parkinson's Boxing Program,** This program is designed to increase mobility, large body movements and fine motor skills . **Patients do not engage in actual boxing.**

For Physician to complete:

1. My patient, named above has the following diagnosis_____.

2. Do you recommend a stress test or consultation prior to your patient beginning an exercise program **Yes/ No.**

3. Do you have any special recommendations or reason why this patients should limit his/her participation or any reason why this patient should not participate.

_____
_____.

3. For individuals with Diabetes, please list any special pre/post exercise recommendations_____.
4. Has patient been treated for incontinence or experienced in continence during physical exertion? **Yes/No.**
5. Does this patient use a, 1. Texas Catheter 2. Suprapubic Catheter 3. Ileostomy 4. Colostomy

My signature confirms that the above named patient is in my care and without medical or physical conditions that would preclude his /her participation in aerobic or anaerobic physical activity. I have indicated any special concerns in the above areas.

Physician Signature:_____Date:_____
Print Name:_____ Phone Number_____