



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

<u>Patient's Name:</u>	<u>Physician Office:</u>
<u>Address:</u>	<u>Referring Physician:</u>
<u>D.O.B</u>	<u>Reason for Referral/Diagnosis:</u>
<u>Phone Number:</u>	

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

**Please circle the specified wellness program below that the patient may engage in at The Works Family Health and Fitness Center.**

                                                                                      

<u>WORKS RX</u>	<u>WEIGHT MANAGEMENT</u>	<u>PRIVATE NUTRITION</u>	<u>OSTEOPOROSIS PREVENTION</u>	<u>PARKINSON'S PROGRAM</u>
Non-member functional movement program that transitions patients into The Works facility safely.	Individual or group based programs that focuses on behavior change utilizing lifestyle approaches. Patient sees Registered Dietitian and Health Coaches.	Offers guidance in nutrition for disease prevention and weight management.	Group settings offers a small group training class 2 times per week for 12 weeks. Education on nutrition throughout the program specific to	Group program focuses on balance, posture, and strength. Dietitian appointments recommended

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.

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