Healthcare Provider,

The following document, “Exercise Clearance and Prescription Form,” is used for the referring healthcare provider to provide clearance for the patient to exercise in Anatomies’ Gateway Program and to make recommendations for exercise prescription.

In order to ensure the safety of this patient, we ask healthcare providers to take less than 5 minutes to complete this form. Thank you for taking the time to improve the quality of healthcare for your patients.

Gateway
Prescribed Wellness Program

EXERCISE CLEARANCE AND PRESCRIPTION FORM

Patient Name: **Patient Phone:**

DOB: / /

I. Please initial one statement that best reflects your exercise clearance recommendation.

1. _____ This patient has **no limitations** to engage in exercise.
2. _____ This patient is **partly limited** to engage in exercise.
3. _____ This patient is **moderately limited** to engage in exercise.
4. _____This patient is **severely limited** to engage in exercise.

Please describe any special considerations:

II. Does this patient require supervision during exercise (choose only one)?
Yes_____ No _____ Sometimes X Discretion of Gateway Staff_____

III. What are **major** goals for this patient? Indicate all that apply:

Weight Loss	Fat Loss	Gain Muscle Mass	Improve Strength	Improve Balance
Improve Flexibility	Stress Reduction	Post Rehabilitation	Healthy Lifestyle	Post-Surgery

Provider Name (print): Provider Phone:

Signature: Date: / /

Would you like to receive a progress report on this patient?
Yes _____ No _____

Mail, fax, or drop off the completed form to:
Gateway Program Director, Anatomies
Ph. (601) 579-9555; Fx. (601) 271-7980
120 98 Place Blvd.
Hattiesburg, MS 39402