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**Physician Consultation Form**

Date:\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The patient listed above is requesting entrance into the Oncology Exercise Program at Upper Valley Medical Center. This is a six-week program designed for patients currently in or within one year of completing treatment for cancer. It is designed as a safe and effective intervention for individuals to exercise while being supervised by a Certified Cancer Exercise Trainer through the American College of Sports Medicine.

Classes are designed to address strength, flexibility, and cardiovascular performance in a group setting, but structured and directed in a way to meet the needs of each individual. The goal of this program is to improve the overall quality of life and well-being of participants in a safe and therapeutic environment. If you deem appropriate, please indicate your approval and any recommendations you may have regarding the participants inclusion in the Oncology Exercise Program.

\_\_\_ The individual may participate without restrictions in the program

\_\_\_ The individual may participate in the program, however please adhere to the following restrictions:

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\_\_\_ The individual should not participate in the program at this time

Is the individual on any medications, that you are aware of, that would affect his/her response to exercise? Yes No Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have consulted with the above patient regarding appropriate level of activity and exercise, and have informed them of the any potential adverse conditions and consequences, including death, that may result if the patient exceeds levels of exercise/activity I have recommended.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date

I hereby authorize the above-named Physician to complete this Physician Consultation Form, including all requested information contained herein.

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Patient Signature Date