



ProHealth West Wood
 Health & Fitness Center
 2900 Golf Road
 Pewaukee, WI 53072
 262-650-8000
WestWoodFitness.org/MyFitRx

Healthcare Provider Exercise Referral

I give consent to ProHealth West Wood Health & Fitness Center to send my healthcare provider this information for an exercise recommendation.

Section A: Patient to complete

Patient Name: _____

Provider Name: _____

DOB: _____

Patient Signature: _____

Phone: _____

Date: _____

Section B: Provider to complete

The patient noted above has requested to enroll in the MyFitRx program at ProHealth West Wood Health & Fitness Center, which requires a healthcare provider exercise referral.

Based on the patient's responses to the Pre-Activity Health Screening, the most recent guidelines from the American College of Sports Medicine® (ACSM) recommend requesting an acknowledgement from their healthcare provider prior to engaging in and/or resuming an exercise program.

Please check one of the following statements:

- I DO NOT RECOMMEND** this member's participation in any exercise at this time. This member should undergo further evaluation or testing outside of West Wood before initiating an exercise program.
- I RECOMMEND** this member's participation in an exercise program, beginning with light to moderate intensity exercise, with gradual progression, as tolerated, following ACSM guidelines.

MyFitRx Pathway:

- | | |
|---|---|
| <input type="checkbox"/> Cancer Fitness | <input type="checkbox"/> Functional Fitness |
| <input type="checkbox"/> Cardiac Fitness | <input type="checkbox"/> Orthopedic Fitness |
| <input type="checkbox"/> Cognitive Health | <input type="checkbox"/> Pulmonary Fitness |
| <input type="checkbox"/> Diabetes Fitness | <input type="checkbox"/> Transitional Care |
| <input type="checkbox"/> Fit for Surgery | <input type="checkbox"/> Weight Management |

Exercise Restrictions or Recommendations: *(If applicable)*

Provider Name: _____

Provider Signature: _____

Date: _____

Please return or fax completed referral to ProHealth West Wood Health & Fitness Center.

Fax: 262-650-8279

NOTE: THIS INFORMATION IS CONFIDENTIAL and intended ONLY for the purpose of receipt and review by the patient and healthcare provider named on this form and by ProHealth West Wood Health & Fitness Center. If you wrongly receive this information, please telephone and return the material to the sender immediately; any expenses incurred in such a return will be fully reimbursed. Any efforts made toward wrongful review or disclosure of this information may result in prosecution.

