Kaleida Health

DOWNTIME
☐ Entered into electronic record after downtime
date time
initials

Patient Name
Date of Birth Admission/Visit Date Site
Medical Record Number Financial Number
Patient ID Area

BARIATRIC APPLICATION PACKET

MEDICAL CLEARANCE FORM/PT ASSESSMENT

This page to be completed by Referring Primary Care Physician.

(Patient) _____, DOB: _____ wishes to take part in an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, muscular strength and endurance. Please identify any recommendations or restrictions for your patient's fitness program below (Physicians Recommendations).

Physician's Recommendations/ Physical Therapy Referral

	I am not aware of any restrictions toward participation in a fitness program.
	I believe the applicant can participate, but urge caution because:
	The applicant should not engage in the following activities:
	I recommend the applicant not participate in the above fitness program.

_____ _____
Physician's Signature Date/Time

Physician's Name (Print)	Phone:	Fax:
Address:	City:	State & Zip: