



The Health & Fitness Center  
 at Washtenaw Community College  
 4833 East Huron River Drive  
 Ann Arbor, MI 48105  
 734-975-9950  
[wccfitness.org/MyFitRx](http://wccfitness.org/MyFitRx)

# Healthcare Provider Exercise Referral

## Section A: Patient to complete

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

Phone \_\_\_\_\_

I give consent to The Health & Fitness Center at Washtenaw Community College to send my healthcare provider this information for an exercise recommendation.

Provider Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## Section B: Provider to complete

The patient noted above has requested to enroll in the MyFitRx program at The Health & Fitness Center at Washtenaw Community College, 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 the center 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 The Health & Fitness Center at Washtenaw Community College.**

Fax: 734-975-9958

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 The Health & Fitness Center at Washtenaw Community College. 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.

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