PERSONAL TRAINING PROGRAM
PHYSICIAN REFERRAL FORM

Participant's Name_____ Date_____

Age_____ Birth date_____ Office Phone_____

Address_____ Home Phone_____

1. Date of last completed examination_____
2. Please check any of the following conditions which are pertinent to this participant:

A. Contraindications (etiologic factors which would be absolute contraindications to participation in the TCU Personal Training Program).

_____1. Coronary Artery Disease
_____2. Severe hypertension
_____3. Significant cardiac dysrhythmia
_____4. Significant valvular disease
_____5. Significant EKG abnormality
_____6. Chest pain (anginal type)
_____7. Syncope
_____8. Significant musculoskeletal disorder

B. Risk Factors

____1. Mild hypertension
____2. Hypercholesterolemia
____3. Family history of heart disease
____4. Sedentary Life
____5. Smoking
____6. Obesity
____7. Non-Specific EKG
____8. Diabetes
____9. Abnormal Triglyceride levels

3. Other abnormalities that you are aware of:_____

4. List any medications the applicant is on:_____

Based upon the current review of the health status of _____, I recommend:

_____ No physical activity
_____ Stress Training prior to beginning an exercise program
_____ Progressive physical activity
_____ With the avoidance of:_____
_____ Other Specific Recommendations:_____
_____

_____ Unrestricted physical activity – start slowly and build up gradually

Signed:_____,M.D. Date:_____
Name of Physician:_____ Phone:_____

RETURN TO: **Molly McGregor**
Assistant Director of Fitness & Wellness
Texas Christian University
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