Date: ____________________________

Dear Doctor: ____

Your patient, ____ is interested in joining the Wellness Center exercise program at Helen Hayes Hospital, which is a supervised, unmonitored, program using equipment for lower and upper extremity strengthening and aerobic exercise.

Patients provide us with a detailed health questionnaire and medication list. However, we also request that you provide us with information that might impact on their exercise program.

Please check all that apply in the list below:

Cardiovascular Disease
- ❑ Myocardial infarction
- ❑ Percutaneous intervention
- ❑ CABG
- ❑ Chronic stable angina
- ❑ ICD
- ❑ Pacemaker
- ❑ LVEF<40%
- ❑ Atrial fibrillation
- ❑ Peripheral arterial disease
- ❑ Other ____________________

Allergies ____

____

Lung Disease
- ❑ COPD
- ❑ Interstitial Fibrosis
- ❑ Asthma
- ❑ Other __________________

Musculoskeletal Disease
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Chronic pain syndrome
- ❑ Spinal stenosis

Neurological Disease
- ❑ Stroke
- ❑ Spinal Cord Injury
- ❑ Brain injury
- ❑ Multiple Sclerosis
- ❑ Dementia
- ❑ Seizures
- ❑ Peripheral neuropathy

Other Chronic Conditions
- ❑ Diabetes
- ❑ Hypertension
- ❑ Chronic kidney disease
- ❑ Peptic ulcer disease
- ❑ Anemia

❑ My patient may participate in the Helen Hayes Hospital Wellness Program

❑ My patient may participate in the Helen Hayes Hospital Wellness Program with the following limitations:

____

❑ Exercise is contraindicated for my patient

Physician's Signature: ____ Date: ___________________

RETURN THE FORM TO YOUR PATIENT OR HELEN HAYES HOSPITAL WELLNESS CENTER

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993
Attention: PT Scheduling Fax: 845-786-4031

If you have any questions in regards to the program please contact our Wellness Center Scheduling Staff at 845-786-4194 or 1-888-70-REHAB EXT. 4194. Thank you.