

**MEDICAL REFERRAL FORM**

PHYSICIAN INFORMATION:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Dear Doctor,

Your patient \_\_\_\_\_ wishes to start an exercise program. The physical activity program consists of cardiovascular, strength and flexibility training. Please indicate if there are any restrictions or contraindications in regards to starting an exercise program.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you,

Leslie Salmon Jones

\_\_\_\_\_ has my approval to begin an exercise program with the above recommendations and restrictions.

Physician's signature \_\_\_\_\_

Date \_\_\_\_\_