

Date: \_\_\_\_\_

Dear Doctor: \_\_\_\_\_

Your patient, \_\_\_\_\_ is interested in joining the Osteo Exercise Class 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

**Advanced Directives:**  Full Code  DNR  Do not intubate

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My patient may participate in the Helen Hayes Hospital Osteo Exercise Class.

My patient may participate in the Helen Hayes Hospital Osteo Exercise Class with the following limitations:

\_\_\_\_\_

Exercise is contraindicated for my patient

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_