PUSHING BOUNDARIES
Exercise, health and hope for people with paralysis

Medical Clearance for Fitness Training at Pushing Boundaries

Your safety is our primary concern. It is important that your physician is aware of the intensity of our program and is able to fully understand the program you are requesting to participate in. The completed medical release form will be used in determining whether our program is appropriate for you.

I hereby give my physician permission to release any pertinent medical information from any medical records to Pushing Boundaries. All information will be kept confidential.

_____ _____
Client Signature Date

Information requested for_____ Reason for clearance: ***Intensive Exercise Therapy Program***

Physician's name (Print) _____ Phone_____

Address_____ Fax_____

For Physician Use Only

Exercise Therapy is a regimen of full body physical activities designed and prescribed for specific therapeutic goals to restore musculoskeletal function, increase strength, endurance, range of motion, or to reduce pain caused by diseases or injuries to increase independence. We do not provide Physical Therapy.

Pushing Boundaries provides intensive, repetitive, and restorative therapy for the purpose of regaining function. Duration of sessions are 2-3 hours in length occurring several times per week. Criteria to participate include (but are not limited to) cognition, cardiovascular capacity, bone density, and overall safety of participating in an intensive exercise therapy based program.

Activities may include active/passive/FES cycling, full body weight standing and gait training, resistive exercise, mat/floor work, body-weight-supported treadmill training, and cardio. Please contact us if you have any questions about the services we provide.

Please check one of the following statements:

___ I concur with my patient's participation with NO RESTRICTIONS.

___I concur with my patient's participation in an intensive exercise based program **given the following restrictions**:

_____

___ I DO NOT CONCUR with my patient's participation in an intensive exercise based program.

Reason: _____

Is this client safe to weight-bear in a standing frame? **Yes No** Date of bone density scan _____ (scan required if NWB > 12 months)

Please list any medication(s) that could affect blood pressure or balance: _____

Please comment on client's cardiopulmonary health: _____

_____

Other Medical Precautions / Recommendations _____

___ Please provide me with quarterly updates as to my patient's progress. (pending release of information signed by client)

___ I would like to see my patient focus on the following:

__ Balance
__ Gait Mechanics
__ Coordination
__ Conditioning
__ Strength Training
__ Flexibility
__ Other (Describe)
_____

Additional Comments:_____

Physician Name (Print): _____ Clinic Address: _____

Physician Signature: _____ Date: _____

Pushing Boundaries 4162 148th Ave. NE Redmond, WA 98052 Phone: 425-869-9506 Fax: 425-869-9482
www.Pushing-Boundaries.org