Medical Fitness and Wellness Group

MEDICAL EXERCISE PRESCRIPTION REFERRAL FORM

PATIENT'S NAME: _____ DOB: _____ DATE: _____

HEALTH CARE PROVIDER'S NAME: _____ SIGNATURE: _____

PRESCRIBED SERVICE(S)

- ☐ Medical Exercise for Chronic Conditions
- ☐ Exercise (strength training/Cardio) for Weight Loss
- ☐ Nutrition for Weight Loss
- ☐ Corrective Exercise for Core Strengthening
- ☐ Medical Massage Therapy/Stretch Therapy
- ☐ Other

PHYSICAL ACTIVITY RECOMMENDATIONS

Type of physical activity:	Aerobic	Strength
Number of days per week:		
Minutes per day:		
Total minutes per week*:		

REFERRAL TO HEALTH & FITNESS PROFESSIONAL

Name: **Medical Fitness and Wellness Group**

Phone: 770-623-4078

Address: 10700 Medlock Bridge Road
Suite 105 Johns Creek GA, 30097

Web Site: www.exercise4prevention.com

Follow-up Appointment Date: _____

Notes: _____