PHYSICIAN REFERRAL FORM

I. Name: _____ Date: _____

Gender _____ Birthdate: _____

Address: _____

_____

Phone: Home _____ Work _____

II. REASON FOR REFERRAL (Please check)

1) Patient's Request: _____

2) Physician Recommendation: _____

a) Specific Concerns:

*PROGRAM Health Fitness _____

Cardiac Rehab _____

III. HEALTH HISTORY & PHYSICAL

1) Does patient have past and/or present history of: (Please check)

*a) Heart Disease _____ b) Lung Disease _____ c) Kidney Disease _____

d) Liver Disease _____ e) Orthopedic Problems _____ f) Hypertension _____

g) Obesity _____ h) Diabetes _____ i) Other _____

Any patient with documented history of heart disease (i.e., MI, CABG, Angioplasty, pace, etc.) are only eligible for Cardiac Rehab Program.

Please comment on any checked item: _____

_____

Date of latest physical exam _____ BP _____/_____ Weight _____ lbs.

Comments: _____

I approve of his/her participation in the Mercy Medical Center Health Fitness Program.

Sign: _____ Phone: _____

Print: _____

PLEASE RETURN TO: MERCY HEALTH CENTER OF NORTH CANTON
Health Fitness
6200 Whipple Avenue, N.W.
North Canton, Ohio 44720
PHONE: 330-966-8997 FAX: 330-966-8898

I, _____, do hereby make application to the Mercy Medical Center, Center for Health Promotion, to be accepted and permitted to participate in its Health/Employee Fitness Program. In consideration of being accepted into this program, I do acknowledge that I am aware of the risks involved in participation in such a program and on behalf of myself, my heirs, executors, administrators, and assigns, waive, release and discharge Mercy Medical Center and all of its agents and employees from any claims or demands which I now have or at any other time in the future may have resulting from any illness, injury or occurrence, occurring during or resulting from participation in this program.

I attest that I am physically fit to participate in this Health/Employee Fitness Program and that my medical condition to do so has been verified by a licensed medical doctor.

Signature _____ Date _____

Name and Address of Physician:

_____

_____

_____

NOTICE: It is recommended that you have a yearly physical examination, consulting your physician about a health/employee fitness program that you intend to participate in, and follow his recommendations concerning a fitness program for you as an individual. In signing this consent form, you state that you have read and understood the above. You enter into the program willingly and may withdraw at any time.