Health & Hearts
Exercise Physiology Clinic

Name ____

Date of birth ___ /___ /___ ☐ Male ☐ Female

Address ____

Phone ____________________________ Email: ______________________________________

Reason for Referral

☐ Motivation
☐ Physical assessment (body composition, strength, flexibility, cardiorespiratory fitness)
☐ VO2 max Test
☐ Weight management/loss - Resting Metabolic Rate Test
☐ Exercise prescription for early onset of symptoms or control risk factors:
- ☐ Joint Pain/Discomfort
- ☐ Hypertension
- ☐ Sedentary Lifestyle
- ☐ Glucose Intolerance
- ☐ Frailty
- ☐ Hypercholesterolemia
- ☐ Depression/stress
- ☐ Obesity/Weight gain
- ☐ Low physical fitness/condition
- ☐ Osteopenia

☐ Review current exercise programme
☐ Exercise programme for management of current injury/condition:
- ☐ Cardiovascular/ Coronary Artery
- ☐ Chronic musculoskeletal
- ☐ Neuromuscular
- ☐ Metabolic
- ☐ Respiratory
- ☐ Cancer

I certify that this patient has medical clearance to participate in an exercise programme designed accordingly by an accredited exercise physiologist.

Doctor's Signature____ Date___ /___ /___

Doctor's Name ____

Ph: ______________________________________ Fax: __________________________________

Email: ____

☐ I wish to receive patient progress reports via fax / email