Brock-Niagara
Centre for Health & Well-Being

DATE ________________

Dear Doctor _________________:

Your patient, ____________________ wishes to begin our Heart Strong Exercise Program at the Brock-Niagara Centre for Health and Well-Being. __________ will be participating in an exercise program that will consist of cardiovascular conditioning, strength training, balance training and flexibility exercises. We would appreciate your support towards your patient's fitness goals.

As ____________'s care provider, you will have a thorough understanding of his/her past medical history and be able to recommend if any diagnostic testing is necessary or provide us with any restrictions that you feel necessary in regards to their exercise regime before they begin to exercise with us.

Your patient will be exposed to the following inherent risks, including but not limited to:

- all manner of injury from physical exertion and cardiovascular output, including dizziness, shortness of breath, chest discomfort, leg cramps, sprains and/or strains;
- all manner of injury resulting from misuse, non-use and/or failure of any equipment;
- all manner of injury from exerting and/or stretching various muscle groups;
- all manner of injury arising from tripping and/or falling and impacting against the floor surface, walls, apparatus/equipment, the ground, other participants, or trainers;
- all manner of injury arising from falls during balance activities;
- abnormal blood pressure, lightheadedness or fainting, and irregular heart beat and in rare cases, HEART ATTACK, CARDIAC ARREST AND EVEN DEATH.

Every effort will be made to minimize the risks during your patient's participation in the Heart Strong Program. Staff will be trained in basic cardiopulmonary resuscitation (CPR), first aid and will have access to an Automated External Defibrillator.

In order to participate in our program, we would require ______________ to undergo an exercise stress test. We understand that ____________ has experienced a cardiac event. Could you please order an exercise stress test for ______________ and have the results faxed to us at 905-378-5724. Would you also sign this letter and fill in any other recommendations that you may have for ______________ as it pertains to an exercise program?

Please indicate in the space below any exercise restrictions or other testing to be performed.

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Signed: Dr.____________________________________

Date:____

Thank you for your involvement with the Brock-Niagara Centre for Health and Well-Being. Please feel free to contact me for any further information that you require.

Ally Fast, R.Kin., CSEP-CEP
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