Brock-Niagara
Centre for Health & Well-Being

DATE _____

Dear Doctor _____:

Your patient, _____ wishes to begin our Therapeutic Exercise for Amputees in Motion (T.E.A.M.) 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 T.E.A.M. Program. Staff will be trained in basic cardiopulmonary resuscitation (CPR), first aid and will have access to an Automated External Defibrillator.

Please check the appropriate circle below regarding whether your patient can partake in exercise with no restrictions, or exercise with restrictions and/or further diagnostic testing. If you feel this program is inappropriate for your patient at this time, please let them know verbally.

No Exercise Restrictions:

_____ is able to begin an exercise program with the Brock T.E.A.M. Program with no restrictions.

Please check this circle for no restrictions.

Exercise Restrictions:

_____ is able to exercise with us, but you would like to place certain restrictions on his/her program.

Please check this circle if restrictions are required and list below.

_____

_____

Diagnostic Testing:

It is my recommendation that _____ undergo the following diagnostic testing before they initiate an exercise program with the Brock-Niagara Centre for Health and Well-Being.

Please check this circle if you require further testing and then indicate tests below.

Test(s) to be performed:

_____

_____

Exercise Restrictions once we receive test results from your office:

_____

_____

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.

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