Treating Physician Medical Clearance/Consent

Dear Dr._____

Your patient _____ would like to begin a program for Fall Prevention, which will include exercises to strengthen upper body/lower body/ and trunk musculature; enhance balance and posture; and advice on lifestyle changes to decrease their risk of falling as well as strategies to recover from a fall. We would appreciate your medical opinion of and recommendations for _____(patient's name) as it pertains to participating in a regular exercise program.

Please provide the following information, and return this for to the following:

Center for Balance, Gait & Fall Prevention
A Division of HVCPA
15 Mt Ebo Road South; Brewster, NY
(P) 845/ 878-9078

1. ***Are there specific concerns or conditions our staff should be aware of prior to this individual's engaging in regular exercise at out facility? Yes No***
   a. ***If YES please specifiy_____***
   _____

2. ***Are there any medication(s) that your patient is currently taking that may impact on their ability to engage in a regular exercise program, or which may impact their ability to maintain normal gait, balance and reactive responses? If any, please note:***
   _____
   _____
3. ***Does your patient currently experience any visual or auditory concerns? If yes, please note:***
   _____
   _____
4. ***Does your patient currently suffer from orthostatic hypotension? Yes No***
5. ***Does your patient currently show any cognitive impairment? If yes, please note:_____***
   _____
6. ***Does your patient currently experience any neuropathic or neurological issues? If yes, please note:***
   _____
   _____
7. ***Has your patient had a bone density exam? Yes No If yes, please note the results and when the test was performed? _____***

Based upon the information you provided, please check off the appropriate answer

_____ I agree to the participation of this individual in regular exercises activity at your facility

_____ I DO NOT AGREE that this individual is a candidate for participation in regular exercises activity at your facility

Physician's signature: _____

Physician's name: _____

Address: _____

Thank you for your consideration and cooperation.