Return via email: xxxxx@xxxx.xxx

Personal Training Referral Form

Referring Provider Name: ______________________________ Agency: ______________________

Referral Phone #: ________________________ Email: ______________________________

——————————————————Patient Demographic Information——————————————————

*Patient Name: ________________________________ *DOB: ______________ Sex: __________

*Email Address: ____

Address (incl. zip): ____

*Main phone #: __________________ Alt phone #: __________________ SSN: ______________

Emergency Contact: ________________________ Relationship __________ Contact #: ____________

Primary Care Physician: __________________________________ Phone #: __________________

Current or Past Therapist: ___________________________ Contact Info: ______________________

————————————————————Clinical Information————————————————————

Reason for Referral: ____

Previous Personal Trainer Name ______________________________ Contact #: _______________

———————————————————Current Medical Information———————————————————

***Does your client experience (check all that apply):**

O Chest discomfort with exertion	**O Dizziness, fainting, blackouts**
O Unreasonable breathlessness	**O Ankle swelling**
O Burning or cramping sensations in the lower legs when walking short distances	**O Unpleasant awareness of a forceful, rapid, or irregular heart rate**

****If any of the above are selected, fax "Medical Release Form" to PCP office.****

***Has your client performed planned, structured physical activity for at least 30 minutes at a moderate intensity on at least 3 days per week for at least the past 3 months?** O Yes O No

***Has your client had or do they currently have (check all that apply):**

O A heart attack	**O Heart failure**	**O Congenital heart disease**
O Heart surgery, cardiac catheterization, or coronary angioplasty	**O pacemaker/implantable cardiac defibrillator/rhythm disturbance**	**O Diabetes**
O Heart valve disease	**O Heart transplantation**	**O Renal disease**

****If yes AND any of the above are selected, fax "Medical Release Form" to PCP office.****

Current Medications (Please include dose and frequency taken. Attach list of needed):

____

____

Additional Info/Notes: ____

Signature of Referral Source: ___________________________________ Date: ________________