SOUND FITNESS

DRx

Doctor Referred Exercise Program

REFERRAL FORM - Must be completed and signed by a qualified medical professional.

Name of Patient: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone: _____ **Is this patient currently exercising regularly?** Y / N

Choose One or More Referral Tracks		
☐ Diabetes Management	☐ Healthy Heart	☐ Pre/Post Surgery Rehab
☐ General Health	☐ Osteoporosis	☐ Weight Loss
☐ Low Back Pain	☐ Neck Pain	☐ Other (please explain)

Contraindications that we should know about: _____

_____

_____

Desired outcome of DRx program, or other information that would be helpful for us to know about the patient: _____

_____

Doctors Signature _____ Date_____

Practice Name: _____

Doctor's Office Phone #:_____Fax #: _____

PLEASE FAX THIS FORM BACK TO (252) 639-2504

For Office Use: Staff Initials:☐_____ Pass Exp:_____

Appt EO:_____ Appt WE:_____