CEMR
CENTER *for*
EXCERCISE MEDICINE
& REHABILITATION
VALDOSTA STATE UNIVERSITY

PHYSICIAN REFERRAL REQUEST

Date________________

Patient ___________________________________

DOB_______________

1. Are there specific concerns or conditions our staff should be aware of before this individual engages in exercise at our facility? YES / NO
   If YES, please specify: ____

   ____

   ____

2. Please list your specific recommendations, in any, for exercise testing and training.

   ____

   ____

3. Please attach any information that may assist in proper exercise programming including, but not limited to, previous exercise tests, most recent history and physical exam, and/or laboratory results.

Physician name (printed) ____________________________

Address ____

Telephone ___________________ Fax _________________

Physician signature _________________________________ Date ___________________

Please return this form and any additional patient information, to:

Lindsay Freidhoff, MSEP, ACSM EP-C, EIM-II
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Thank you for your continued support of VSU and the Center for Exercise Medicine and Rehabilitation!