
Wellness and Fitness
PHYSICIAN REFERRAL

Your patient, _____, would like to begin a program of exercise at Valdosta State University's Center for Exercise Medicine and Rehabilitation. We would appreciate your medical opinion and recommendations concerning his/her participation in exercise testing and training.

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, including hemodynamic and blood glucose monitoring during exercise.

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, along with the *Release of Medical Information* and any additional patient information, to:

Lindsay Freidhoff, MSEP, ACSM EP-C, EIM-II

Director, Center for Exercise Medicine and Rehabilitation-Fitness & Wellness

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Thank you for your continued support of VSU and the Center for Exercise Medicine and Rehabilitation!
