CEMR
CENTER for EXERCISE MEDICINE & REHABILITATION
VALDOSTA STATE UNIVERSITY

Phone: 229-253-2887
Fax: 229-219-1284

PHYSICIAN REFERRAL

Your patient, _____, DOB _____, 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 and any additional patient information, to:

Andrew Diamond, MSEP, ACSM EP-C
Director, Center for Exercise Medicine and Rehabilitation
College of Nursing and Health Sciences
229-253-2887 (phone)
229-219-1284 (fax)
amdiamond@valdosta.edu

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