HEALTHCARE PRACTIONER REFERRAL

Complete and fax to the gentleGYM at 319.260.2242.

924 Viking Rd, Ste 101 • Cedar Falls, IA 50613 • 319.260.2240 • thegentlegym.org

I believe the below patient can benefit from an independent exercise program carried out under the supervision of the qualified gentleGYM staff.

Title	Practitioner Name
Practitioner Phone	

Patient Name	
Patient DOB	Patient Phone

Please list any restrictions or recommendations for gentleGYM staff to consider and/or follow when assessing and prescribing exercise:

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As part of the gentleGYM, clients will be tracking activity and undergoing a 60-day re-assessment. Progress notes can be sent to providers as requested and approved by the patient.

PLEASE SIGN

By signing, I am affirming that I recommend the above-named patient for an exercise program and I have noted any recommendations or restrictions above. This form will serve as medical clearance for exercise.

Physician Signature: ____________________________ Date: __________