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Please Print

Date _____

Patient Name _____ Patient Phone _____

Treating Therapist _____ Release Date _____

Therapist Address _____ Therapist Phone _____

Diagnosis _____

Current Status at Discharge:

Pain: ___ over 10 Intermittent or Constant HEP Yes or No

Restrictions/Active ROM _____

Precautions/Limitations _____

Other Notes _____

What components of the fitness assessment do you wish patient to participate in?

Sub-max VO2 Bicycle Ergometer Exercise Test **Yes or No**

Strength (push ups and hand grip) **Yes or No**

Flexibility (Sit and Reach) **Yes or No** Body Composition **Yes or No**

Aquatics **Yes or No** Specify? _____

Comments _____

