6200 Pfeiffer Road
Cincinnati, OH 45242
Phone (513)985-0900 Fax (513)985-0918

Post Rehab
Physician Consult

Please Print

Patient Phone ______________________

Patient Name ____________________________________ Date _______________________________

Physician Name __________________________________ Physician Phone______________________

Physician Address ________________________________

____

The above individual would like to participate in the post rehab program at the TriHealth Fitness & Health Pavilion (the "Pavilion"). The post rehab program is intended for those who have recently completed rehabilitation or therapy and is a safe means for individuals to continue on a follow up exercise program, under the guidance of an Athletic Trainer, for up to three months. The goal of the post rehab program is to improve health status and achieve independence in an exercise program. Please review the following information regarding the equipment and facilities available at the Pavilion to be offered to the individual. Please indicate your approval and recommendations regarding the individual's use of the equipment and facilities and participation in the post rehab program at the Pavilion.

Cardiovascular Equipment Available
Treadmills, upright bikes, recumbent bikes, upper body ergometers, elliptical machines, arc trainers, rowers, cross country skiers.

Strength Training Equipment Available
Cybex, Matrix, Hammer, Nautilus and Star Trac stationary equipment. A variety of free weights includingdumbbells, barbells, smith machine, squat rack, and Olympic benches.

Other Facilities Available
Warm water therapy pool, lap pool, leisure pool, aerobic classes, aquatic classes, whirlpool, sauna, steam room, indoor and outdoor tracks.

Based on the health history information and your recommendations, an exercise program will be developed for the individual.

_______ This patient may participate without restriction in a post rehab program at the Pavilion.

_______ This individual may participate in a post rehab program at the Pavilion with the following restrictions:____
____
____

Are you aware of any medication this patient is taking regularly that would affect his/her response to exercise? If so, please describe.____
____

I have consulted with my patient concerning acceptable levels of exercise and I have informed my patient of the potential adverse health consequences, including death, that may result if my patient exceeds levels of exercise that I have recommended.

____ ______________________
Physician's signature Date