FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Date: _____/_____/_____

Dear Doctor: _____

Your Patient: _____ **Date of Birth:** _____/_____/_____

Diagnosis: _____

Date of Diagnosis: _____/_____/_____ **State of Diagnosis:** _____

Your patient would like to begin a program of exercise in our Parkinson's Wellness Recovery program within the YMCA of Greenville. We would appreciate your medical opinion and recommendations concerning his/her participation.

Our Parkinson's Wellness Recovery at the YMCA of Greenville will entail:

1. **PWR!** Personal training (one on one)

2. **PWR!** and pedaling class combo (group exercise)

3. **PWR!** Circuit training (could be either one on one or in a group exercise setting)

PLEASE NOTE: Although we do have an AED on the premises, and our Wellness Coaches, pedaling instructors and personal trainers are CPR certified and are nationally certified to work with Parkinson's disease patients, the above-mentioned program formats are monitored. If the patient comes into the facility on their own accord, this time will not be monitored.

THE PATIENT IS ELIGIBLE IF:

- The patient has a clinical diagnosis of idiopathic PD (the most common form of Parkinsonism in which the cause of the condition is unknown).
- Graded at Hoehn and Yahr stage I, II or III when off medication.

THE PATIENT IS INELIGIBLE IF THE FOLLOWING EXISTS:

- Clinically significant medical disease that would increase the risk of exercise-related complications (e.g. Cardiac or pulmonary disease, hypertension or stroke).
- Dementia as evidenced by a score less than 116 on the Mattis Dementia Rating Scale.
- Other medical or musculoskeletal contraindications to exercise.

This member is ready to begin their wellness journey with us.
If you have any questions, please contact:

Staff Name: _____

Staff Email: _____

Branch Name: _____

Branch Address: _____

Branch Phone Number: **(** _____ **)** _____ **-** _____ **ext.** _____

Branch Fax Number: **(** _____ **)** _____ **-** _____

Prescreening Questions for the patient to confirm with physician:

Have you taken any heart medications?	**Yes** ☐	**No** ☐	Have you experienced unreasonable breathlessness?	**Yes** ☐	**No** ☐
Have you ever had a heart attack?	**Yes** ☐	**No** ☐	Do you take blood pressure medication?	**Yes** ☐	**No** ☐
Have you ever had heart surgery?	**Yes** ☐	**No** ☐	Are you diabetic or take medicine to control blood sugar?	**Yes** ☐	**No** ☐
Have you ever had heart failure?	**Yes** ☐	**No** ☐	Is your blood cholesterol >240 mg/dl?	**Yes** ☐	**No** ☐
Have you ever had pacemaker/implantable cardiac defibrillator/rhythm disturbance?	**Yes** ☐	**No** ☐	Females: Have you had a hysterectomy or are you postmenopausal?	**Yes** ☐	**No** ☐
Have you ever had cardiac catheterization?	**Yes** ☐	**No** ☐	Have you experienced dizziness, fainting or blackouts?	**Yes** ☐	**No** ☐
Have you ever had coronary angioplasty?	**Yes** ☐	**No** ☐	Have you experienced any falls within the last 3 months? If so, about how many?	**Yes** ☐	**No** ☐
Have you ever had heart valve disease?	**Yes** ☐	**No** ☐	Do you smoke?	**Yes** ☐	**No** ☐
Have you had a close blood relative who had a heart attack before age 55 (father or mother) or 65 (brother or sister)?	**Yes** ☐	**No** ☐	Do you have musculoskeletal problems that would prevent you from exercising?	**Yes** ☐	**No** ☐
Have you ever experienced chest discomfort with exertion?	**Yes** ☐	**No** ☐	Do you have concerns about the safety of exercise?	**Yes** ☐	**No** ☐
Are you physically inactive, exercising fewer than 30 minutes per day/3 days per week?				**Yes** ☐	**No** ☐

PLEASE CHECK ONE BOX:

I recommend that the applicant NOT participate in the Power Wellness Recovery (class) fitness program. ☐

I recommend that the applicant participate in the Power Wellness Recovery (class) fitness program. ☐

Physician Signature: _____ **Date:** ___/___/___

Print Physician Name: _____

Hospital Affiliation: _____

Address: _____

_____

Phone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____