Wellness Center
900 West Central Road
Arlington Heights, Illinois 60005
847.618.3500
www.nchwellnesscenter.com

MedFit$_{Rx}$ Physician's Consent for Exercise

My patient _____has expressed an interest in becoming a member of the **MedFit$_{Rx}$** Program at the Northwest Community Hospital (NCH) Wellness Center.

The NCH Wellness Center needs your written consent before your patient will be allowed to become a member of the **MedFit$_{Rx}$** Program and participate in a goal evaluation appointment performed by a NCH Wellness Center Certified Personal Trainer that includes:

- Blood Pressure and Pulse
- Movement Screening
- Flexibility Assessment
- Body Fat Composition

An individual program will be designed for your patient based on the results of the Exercise Screening Questionnaire and the Goal Evaluation.

Please check the box below and return this consent form to the Clinical Fitness Specialist via fax at 847-618-3509 or medfitrx@nch.org

☐ It is my opinion that this patient is in sufficiently good health to begin an exercise program.

Patient D.O.B. _____ Patient Telephone No._____

PatientAddress_____

_____

_____ _____

Physician's Name (please print) Date Physician's Signature Date