acac Fitness & Wellness Centers x Maple Tree CANCER ALLIANCE

SURVIVORSHIP EXERCISE PROGRAM

Physician Referral Form

Patient Name: _____ Patient Email: _____

Patient Phone Number: _____ Patient DOB: _____

Physician Name: _____ Physician Email: _____

Physician Phone Number: _____

Exercise Restrictions: _____

_____

_____

Medications that may affect exercise response: _____

_____

I hereby give medical approval to the person named above to participate in a post-rehabilitation program that may include cardiovascular, resistance training, and functional conditioning for the body.

Physician's Stamp	Physician's Signature	Date

Fax completed form to patient's preferred acac Fitness & Wellness Center location below.

MIDLOTHIAN, VA
phone 804.378.1600
fax 804.597.2167

SHORT PUMP, VA
phone 804.464.0990
fax 804.597.2316