HAYWOOD
REGIONAL HEALTH & FITNESS CENTER

STEP

Please fax completed form to Marla Larson/Stephen Jennings
Fax: (828) 452-8072

Patient Name: _____DOB: _____

Diagnosis/precautions _____

Insurance _____

Address: _____

Phone number: Home: _____cell: _____

[X] Physical Therapy evaluate and treat

STEP admittance is based on the guidelines from the American College of Sports Medicine (ACSM).

- I authorize the STEP care team to:
- Perform standard pre and post aerobic capacity assessments, strength assessments and body composition assessments.
- Allow participation in group/individual education sessions, including but not limited to dietary consults and consults regarding exercise prescription and exercise safety per ACSM guidelines.
- Upon completion of 60 day STEP program, the above patient is cleared to become a member of the Haywood Regional Health & Fitness Center for independent cardiovascular, strengthening and flexibility exercises.

Limitations or any specific individual guidelines or protocols you want your patient to follow

_____

_____

Physician name: _____ Phone: _____

Signature: _____ Fax: _____

Date: _____