



365 S. Crown Hill Rd.
Orrville, OH 44667
330-684-4732 Fax- 330-684-4742

Physician Referral Form

Dear Dr. _____:

Your patient, _____, DOB _____, would like to begin a program of exercise and/or sports activity at Aultman Orrville Sports & Wellness. After reviewing his/her responses to our health screening questionnaire, we would appreciate your medical advice and recommendations concerning his/her participation in exercise/sports activity. He/She has been informed that you may require him/her to make an appointment with you to review his/her health. This is at your discretion. Please provide the following information and return this form to Aultman Orrville Sports & Wellness.

1. You are receiving this referral form for this individual because:

2. Please provide the following information so that we may contact you if we have any further questions.

I am not aware of any contraindications related to exercise participation for this individual.

I believe the individual can participate in an exercise program, but urge caution because:

I believe the individual can participate in an exercise program, but should not engage in the following contraindicated activities: _____

I recommend the individual **not** participate in an exercise program.

Physician's signature: _____

Physician's name (please print): _____

Address: _____

Telephone: _____ Fax: _____

Member Phone#: _____ Faxed date: _____ Faxed received: _____ Staff Init: _____

I, _____ (*print name*), hereby allow the aforementioned physician to release information to Aultman Orrville Sports & Wellness regarding my medical status for purposes of participating in an exercise and/or sports activity.

Member Signature: _____ Date: _____

Thank you for your help! **The Staff at Aultman Orrville Sports & Wellness**