MEDICAL FITNESS REFERRAL

Referral from a healthcare provider is required to participate in a LIVING FIT fitness program.

Patient Name _____ Date of Birth _____

Referring Healthcare Provider _____

Referring Healthcare Provider Phone Number _____

Patient is referred for (choose the most appropriate program):

- ☐ Cancer Fitness
- ☐ Heart Health Fitness
- ☐ Diabetes Fitness
- ☐ Functional Fitness
- ☐ Fit Before Surgery
- ☐ Orthopedic Fitness
- ☐ Pulmonary Fitness
- ☐ Weight Management

Please list any exercise restrictions or recommendations:

_____

_____

_____

Healthcare Provider Signature _____ Date _____