Kishwaukee Health & Wellness Center
626 Bethany Road
DeKalb, Illinois 60115
815.754.1098
nmkishhwc.com/MyFitRx

MEMBER MEDICALFITNESS Association www.medicalfitness.org

MyFitRx®

Healthcare Provider Exercise Referral

Section A: Patient to complete

I give consent to Northwestern Medicine Kishwaukee Health & Wellness Center to send my healthcare provider this information for an exercise recommendation.

Patient Name ______________________

DOB ______________________

Phone ______________________

Provider Name ______________________

Patient Signature ______________________

Date ______________________

Section B: Provider to complete

The patient noted above has requested to enroll in the MyFitRx program at Northwestern Medicine Kishwaukee Health & Wellness Center, which requires a healthcare provider exercise referral.

Based on the patient's responses to the Pre-Activity Health Screening, the most recent guidelines from the American College of Sports Medicine® (ACSM) recommend requesting an acknowledgement from their healthcare provider prior to engaging in and/or resuming an exercise program.

Please check one of the following statements:

☐ **I DO NOT RECOMMEND** this member's participation in any exercise at this time. This member should undergo further evaluation or testing outside of the Center before initiating an exercise program.

☐ **I RECOMMEND** this member's participation in an exercise program, beginning with light to moderate intensity exercise, with gradual progression, as tolerated, following ACSM guidelines.

I ACKNOWLEDGE the above patient has met the minimum level of activity required to enroll in the MyFitRx program and continue their current therapy.

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Physician Initials

MyFitRx Pathway:

☐ Cancer Fitness
☐ Cardiac Fitness
☐ Cognitive Health
☐ Diabetes Fitness
☐ Fit for Surgery
☐ Functional Fitness
☐ Orthopaedic Fitness
☐ Pulmonary Fitness
☐ Transitional Care
☐ Weight Management

Exercise Restrictions or Recommendations: *(If applicable)*

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Provider Name ______________________

Provider Signature ______________________

Date ______________________

Please return or fax completed referral to Northwestern Medicine Kishwaukee Health & Wellness Center.

Fax: 815.748.6047

NOTE: THIS INFORMATION IS CONFIDENTIAL and intended ONLY for the purpose of receipt and review by the patient and healthcare provider named on this form and by Northwestern Medicine Kishwaukee Health & Wellness Center. If you wrongly receive this information, please telephone and return the material to the sender immediately; any expenses incurred in such a return will be fully reimbursed. Any efforts made toward wrongful review or disclosure of this information may result in prosecution.

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