

**Fitness Center**  
McHenry County College  
8900 U.S. Highway 14  
Crystal Lake, IL 60012  
(815) 455-8551

**Physician's Referral Form**  
**Pertaining to a Fitness Evaluation**  
**and Preventive Exercise Program**

**THIS FORM MUST BE FAXED FROM THE PHYSICIAN TO THE MCC FITNESS CENTER, HAND DELIVERY**  
**OR MAILING IS NOT ACCEPTABLE.**  
**PLEASE FAX TO (815) 455-8599**

**Fitness Center Coordinator:** Joel Chapman

**Dear Doctor:**

Your patient \_\_\_\_\_, is interested in a fitness evaluation and individualized preventive exercise program at the Fitness Center of McHenry County College. The fitness evaluation includes:

- Resting heart rate and blood pressure
- Body weight and skin fold analysis of body composition
- Hamstring/low back flexibility
- Maximal isometric biceps strength
- Sub-maximal bicycle ergometry

Results of the test will be used to implement a preventive exercise program, which may include:

- Cardiovascular exercise
- Strength training
- Flexibility
- Balance training

**In the interest to your patient, and for our information, please complete the following (make sure A to E are all answered).**

- A. This patient has undergone a physical examination within the last year to assess functional capacity to perform exercise. **Yes** \_\_\_ **No** \_\_\_
- B. I consider this patient **(please circle one)**  
**Class I** ... presumably healthy without apparent heart disease  
**Class II** ...presumably healthy with one or more risk factors for heart disease  
**Class III** ..patient is not eligible for this program
- C. Does this patient have any pre-existing medical/orthopedic condition requiring continued or long-term medical treatment or follow-up? **No** \_\_\_ **Yes** \_\_\_  
**Please explain:** \_\_\_\_\_  
\_\_\_\_\_
- D. Are you aware of any medical condition that this patient may have had that could be worsened by exercise?  
**No** \_\_\_ **Yes** \_\_\_  
**Please explain:** \_\_\_\_\_  
\_\_\_\_\_
- E. **Please list any currently prescribed medication(s).** \_\_\_\_\_  
\_\_\_\_\_

Client's Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (xxx-xxx-xxxx)

Street Address \_\_\_\_\_ Phone (W) \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**Referring Physician's Signature** \_\_\_\_\_

Date \_\_\_\_\_

Comments \_\_\_\_\_