Dear Dr. _____

The following patient(s) require medical clearance to participate in BC Women's Hospital & Health Centre's Osteofit program.

Osteofit is a program of falls prevention, education, lifestyle management, agility, strength, balance, and posture that is safe for those with osteoporosis.

Classes are currently being offered in _____ at
(city)

_____ and led by _____.
(facility) *(instructor)*

Please return the attached Medical Clearance Form(s) to:

_____
(Osteofit Instructor)

_____
(Facility)

Fax: _____

Thank you!

Medical Clearance Form

Dear Doctor _____,

Your patient _____ wishes to participate in BC Women's Hospital & Health Centre's Osteofit exercise program. This program will include interactive discussions on topics pertaining to lifestyle management of osteoporosis, agility activities, balance exercises, strengthening exercises, and stretches, all designed to be safe for those with osteoporosis.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advice in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize Dr. _____ to release to

*(Facility)*_____, health information concerning

my ability to participate in an exercise program.

Member's signature _____ Date_____

Trainer's signature _____

Physician's Recommendations

- ❑ I am not aware of any contraindications toward participation in the Osteofit program.
- ❑ I believe the applicant can participate, but urge caution because: _____

  _____
- ❑ The applicant should not engage in the following activities: _____

  _____
- ❑ I recommend the applicant not participate in the above exercise program.

Physician's signature _____ Date_____

Physician's name (print) _____ Phone/Fax _____