MyFitRx®

Healthcare Provider Exercise Referral

Mercy Health – Anderson HealthPlex
7495 State Rd.
Cincinnati, OH 45255
513-624-1871
mercyhealthplex.com/MyFitRx

Section A: Patient to complete

Patient Name _____

DOB _____

Phone _____

Email _____

I give consent to Mercy Health – Anderson HealthPlex to send my healthcare provider this information for an exercise recommendation.

Provider Name _____

Patient Signature _____

Date _____

Section B: Provider to complete

The patient noted above has requested to enroll in the MyFitRx program at Mercy Health – Anderson HealthPlex, 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.

MyFitRx Pathway:

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

Exercise Restrictions or Recommendations: *(If applicable)*

_____

_____

_____

_____

_____

Provider Name _____

Provider Signature _____

Date _____

Please return or fax completed referral to Mercy Health – Anderson HealthPlex.

Fax: 513-624-1875

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 Mercy Health – Anderson HealthPlex. 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.

MERCYHEALTH
Anderson HealthPlex

MEDICAL FITNESS Association CERTIFIED

MyFitRx®

Healthcare Provider Exercise Referral

Mercy Health – Queen City HealthPlex
3131 Queen City Ave.
Cincinnati, OH 45238
513-389-5600
mercyhealthplex.com/MyFitRx

Section A: Patient to complete

Patient Name _____

DOB _____

Phone _____

Email _____

I give consent to Mercy Health – Queen City HealthPlex to send my healthcare provider this information for an exercise recommendation.

Provider Name _____

Patient Signature _____

Date _____

Section B: Provider to complete

The patient noted above has requested to enroll in the MyFitRx program at Mercy Health – Queen City HealthPlex, 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.

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Exercise Restrictions or Recommendations: *(If applicable)*

_____

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Provider Name _____

Provider Signature _____

Date _____

Please return or fax completed referral to Mercy Health – Queen City HealthPlex.

Fax: 513-389-5867

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MERCYHEALTH
Queen City HealthPlex