Physician Referral

Today's Date_____

Physician's Name:_____

Phone:_____

Fax:_____

Patient Name:_____

Birth date:_____

Phone:_____

Your patient has volunteered to participate in an exercise program. This referral is requested for establishing medical clearance for your patient before he/she enters a fitness program for seniors at **Chateau Lake San Marcos.** All fitness classes offered are appropriate for seniors and are taught by qualified instructors. Please provide your recommendations for exercise at this time (check one):

_____is **not cleared** and cannot exercise at this time
_____is **cleared** and can exercise with no restrictions
_____is **cleared** with the following **restrictions**_____

_____

_____

Physician's Signature _____

Date_____