Joint Optimization Program

MEDICAL CLEARANCE and REFERRAL FORM

Patient Name _____ DOB____/_____/_____

Home Phone #: _____ Cell Phone #: _____

☐ **Joint Optimization Program**
Joint (Right/Left): _____
Expected Surgery Date: _____

Needs to work on:

☐ Diabetes Management
Current A1C: _____

☐ Weight Loss
Current BMI: _____

☐ Smoking Cessation

Please send most recent office note with referral

I certify this patient is cleared to start exercising at the Life Fit Wellness Center under the guidance of a Wellness Coach.

Physician's Comments:_____

_____

_____

Physician Signature *Date*

LifeFit Wellness Center
843-522-5635 – Front Desk Phone
843-522-5454 – Fax
843-522-5651 Sydney Boggs
843-522-5661 Cheyanne Genovese

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