



Chelsea Wellness Center
14800 E. Old US 12
Chelsea, MI 48118
734-214-0220
chelseawellness.org/MyFitRx

Dexter Wellness Center
2810 Baker Road
Dexter, MI 48130
734-580-2500
dexterwellness.org/MyFitRx

Healthcare Provider Exercise Referral

Section A: Patient to complete

Patient Name _____

DOB _____

Phone _____

I give consent to Chelsea or Dexter Wellness Center 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 Chelsea or Dexter Wellness Center, 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:

- | | |
|---|---|
| <input type="checkbox"/> Cancer Fitness | <input type="checkbox"/> Functional Fitness |
| <input type="checkbox"/> Cardiac Fitness | <input type="checkbox"/> Orthopedic Fitness |
| <input type="checkbox"/> Cognitive Health | <input type="checkbox"/> Pulmonary Fitness |
| <input type="checkbox"/> Diabetes Fitness | <input type="checkbox"/> Transitional Care |
| <input type="checkbox"/> Fit for Surgery | <input type="checkbox"/> Weight Management |

Exercise Restrictions or Recommendations: *(If applicable)*

Provider Name _____

Provider Signature _____

Date _____

Please return or fax completed referral to your Wellness Center.

CHE Fax: 734-214-0249

DEX Fax: 734-580-2501

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 Chelsea or Dexter Wellness Center. 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.

