LEGACY HEALTH | LEGACY CANCER INSTITUTE

Movement Classes at the Legacy Cancer Institute

Physician Release Form

Physician instructions: Give one copy to patient. Send a scanned copy to Coordinator (info below) via fax or EPIC In Basket (preferred).

Patient instructions: You must review completed form with instructor *before* your first class.

Name of Patient & D.O.B: _____

Diagnosis & Stage: _____

Please specify any medical conditions that might limit this individual's participation in this movement class.

Orthopedic problems:

Neurological problems:

Cardiac Status/Limitations:

Cancer or Metastatic Disease/Limitations:

Other:

Please list any movements or activities this individual should avoid (Example: trunk rotation).

I agree that the individual whose name appears above may participate in the Movement for Health and Fitness Class, taking into consideration the above restriction(s):

_____MD Signature

_____MD Print Name

_____PHONE

_____DATE

Send to Niani Dunner, MPH – Legacy Cancer Healing Center Coordinator
(fax) 503-413-8363 | ndunner@LHS.org
www.legeacyhealth.org/cancerclasses