To: _______________________________  Date_________________

(Physician)
Your patient, _________________________________, has requested to enroll in the WISH-Wellness In Stroke and Head-Injury Program. A Physician Clearance, History and Physical, and other Pertinent Medical Information are required for entrance into this program. Would you please fax the enclosed Physician Clearance Form and other requested medical information to us at your earliest convenience?

A description of the Towson University WISH Program:
The WISH Program is an extension of our LIFEWORx Medical Fitness Program and is designed for patients with documented disease and patients who are at increased risk of developing chronic diseases and conditions. This ongoing program consists of 3-5 exercise sessions per week and runs continuously throughout the year. The activities and exercises selected will be individualized in nature and the participants will work at their own prescribed heart rate. Heart rates will be monitored periodically throughout each session. The four phases of a typical, beginning exercise session include the following:

Warm-up: 5-10 min. warm-up/stretching exercises
Cardiovascular: 20-60 min. of aerobic exercise
Strength Training: 3-5 days/week
Cool-down: 5-10 min. cool-down period

Exercise Prescription (ExRx): Workout frequency will be a minimum of 3 times/week. Initial exercise duration ranges from 20-60 minutes and is determined by initial MET capacity and risk level of patient. The exercise intensity is set at a target heart rate of 50-85% of heart rate reserve based on the maximum heart rate attained during the entry stress test (if completed). Peak exercise training heart rate is set safely below the following symptoms observed in the entry stress test: angina; hypertensive response; decrease in systolic BP; ECG evidence of ischemia, ventricular dysrhythmias and other signs of exertional intolerance. There is a slow progression in duration and intensity of exercise in the program. The speed and amount of increase in duration and intensity is dependent upon the individual’s improvement in fitness level.

THIS PROGRAM WILL BE CONDUCTED / REVIEWED BY CLINICAL EXERCISE PHYSIOLOGISTS FROM TOWSON UNIVERSITY. PROGRAM EMERGENCY MANAGEMENT PROCEDURES INCLUDE: ACTIVATION OF EMS, BASIC LIFE SUPPORT, THE USE OF OXYGEN AND AN AUTOMATIC EXTERNAL DEFIBRILLATOR IF REQUIRED.

PLEASE COMPLETE THE ENCLOSED PHYSICIAN CLEARANCE FORM AND SEND OR FAX ALL REQUESTED MEDICAL INFORMATION TO:

Michael Pavelik, M.S., ACSM CES
Director, Wellness Center
Institute for Well-Being, Towson University
FAX  410-704-8321
PHYSICIAN CLEARANCE FORM

Patient's Name _____________________________________________________ Date _____________
Address ____________________________________________________________________________ D.O.B. ____________
___________________________________________________________________________________ Phone ____________
City State Zip

The above patient is interested in participating in the Towson University WISH Program.
SEE ATTACHED LETTER DESCRIBING THE PROGRAM AND EXERCISE PRESCRIPTION.

REQUIRED MEDICAL INFORMATION TO BE RETURNED TO US (THOSE CHECKED):

____X____ Physician Clearance Form (this form)
____X____ Most recent 12-lead EKG, Labs, H&P
____X____ Discharge Summary
____X____ Most recent Exercise Stress Test conclusions

TO BE COMPLETED BY PHYSICIAN:

Entry Diagnosis: _____Stroke _____Other

______________________________________ ____________________________
Physician's Signature Physician's Phone Number

EXERCISE PRESCRIPTION (ExRx):

Please sign below after selecting an exercise prescription (Option1 or Option 2) or approving the exercise
Prescription parameters as detailed on the attached letter (Option 3).

□ Physician Directed - Option 1:
  20-30 bpm + Resting Heart Rate.

□ Physician Directed - Option 2:
  Heart Rate and MET level from Exercise Stress Test:____________________

□ Recommended by Clinical Exercise Specialists at Towson University Wellness Center - Option 3:
  Target Heart Rate and MET level or RPE ________________________________

If you feel that an alternative exercise prescription is required, please provide an attached
exercise prescription that includes: frequency (times/week), duration (minutes/session), intensity
(heart rate/METS), exercise progression, and types of exercises recommended for this patient and check
here: _______ ExRx Enclosed.

Please enroll my patient in the Towson University WISH Program utilizing one of the above exercise prescriptions:

______________________________________ ____________________________
Physician's Signature Physician's Phone Number

1/21/15