Kirmayer Fitness Center

Medical Referral for Exercise (Physician/Clinician)

Patient Name: _____ DOB: _____

Phone:_____ Email:_____

Reason for Referral (circle)

Muscular Strength Cardiovascular Health ROM Wellness BMI/Wt. Mgmt.

Current Medical Conditions (Check all that apply)

- ☐ Musculoskeletal / Orthopedic
- ☐ Pulmonary
- ☐ Diabetes ___Type I ___ Type II
- ☐ Arthritis
- ☐ Cancer
- ☐ Balance/Fall Prevention
- ☐ Neuromuscular
- ☐ Cardiac
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ Hypercholesterolemia
- ☐ Stress / Depression
- ☐ Other_____

By completing this form, you are not assuming any responsibility for our exercise program; rather, you are identifying any recommendations or restrictions for your patient's fitness program.

- ☐ I am not aware of any contraindications for participation in the fitness program.
- ☐ I believe the patient can participate but with the following restrictions or precautions: _____ _____
- ☐ The patient should not engage in the following activities: _____ _____
- ☐ I recommend that the patient not participate in the fitness program at this time.

I am referring my patient to Kirmayer Fitness Center for a fitness assessment and personalized exercise program. Kirmayer will forward his/her fitness assessment and quarterly reports to my office for inclusion in his/her medical record. I may contact Kirmayer at any time regarding the progress of my patient or to provide further information.

_____ _____

Referring Clinician's Name (Please Print) Signature

_____ _____

Fax # Email

_____

Phone #

{L0046542.1 }**PLEASE SEND TO: KIRMAYER@KUMC.EDU**

*** fax (913) 588-7710 * phone (913)588-1532**

Kirmayer Fitness Center

Authorization for Release of Protected Health Information - (Patient)

Kirmayer Fitness Center Medical Referral Process Overview:
Congratulations on taking a step towards a healthy lifestyle! We welcome all fitness levels and abilities at Kirmayer Fitness Center. New patient referrals meet with a certified fitness specialist for a complimentary one-hour consultation prior to beginning membership. During the consultation, you and the fitness specialist will work together to determine an appropriate action plan for beginning an exercise program.

PLEASE NOTE: Membership costs (and optional individual personal training) are out-of-pocket costs and not covered under most insurance plans and/or Medicare.

I_____(patient), hereby authorize_____(provider) to release the following health information about me (_____) to Kirmayer Fitness Center at The University of Kansas Medical Center, located at 3901 Rainbow Blvd, Kansas City, KS 66160.

The purpose of the disclosure is to assist Kirmayer Fitness Center with designing an appropriate fitness plan for me.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individual identifiable health information as described above for the above purpose.
- I should I choose to revoke my authorization, I should contact my provider and that revocation will not apply to information already provided.
- I understand that Kirmayer Fitness Center who I have authorized to receive the information is not a health plan or health care provider, so the released information is no longer be protected by federal privacy regulations. Any disclosure of information has the potential for unauthorized redisclosure.
- Unless otherwise specified this authorization will expire one year from the date signed.
- I understand that I may receive a copy of this authorization.
- I understand that I am signing this authorization voluntary and that treatment, payment, eligibility for benefits will not be affected whether I sign this authorization.

I authorize the release of my health information to Kirmayer Fitness Center.

SIGNATURE_____ DATE_____

At Kirmayer, we believe…..

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