MEDICAL REFERRAL

To: _____ From: _____
(print first & last name) *(print first & last name)*

_____ Birth Date: _____
(print business name)

_____ _____
(address) *(address)*

_____ _____
(city, state, zip) *(city, state, zip)*

_____ _____ _____ _____
(business phone) *(fax)* *(home phone)* *(cell phone)*

Dear Physician or Health Care Practitioner,

By my signature below, I request and authorize you to release to the Bellingham Tennis Club LLC any and all medical information relevant to my participation in exercise and athletic based programs. Please be certain to identify any and all limitations that I may have so that the Bellingham Tennis Club can tailor my programs accordingly. In addition, I authorize you to provide medical information to the Bellingham Tennis Club upon their written request to you. This authorization shall expire one year from today's date.

Your Patient, _____ Today's Date: _____

Your patient, _____, wishes to participate in an exercise and fitness program at the Bellingham Tennis Club. The program may include strength training, cardio training, and stretching; using a variety of equipment. A consultation with your patient and/or their Client Information Questionnaire revealed conditions warranting more information from you. In addition to information on the following conditions and your specific recommendations to your patient regarding exercise, nutrition, and these conditions, please make recommendations regarding their current health status and results of any Cholesterol, Glucose, Blood Pressure, and Exercise Stress tests done within the past year. If you require more detailed information about the specific programs in which your patient will be involved, please ask for the Club's Fitness Director at 360-733-5050.

Please use back side or additional sheets if you need more room.
Please describe information that pertains to developing a fitness program for this individual.

1. Conditions*:*_____
_____
_____
_____

2. Limitations or Restrictions: _____
_____
_____
_____

3. Suggestions for Exercise Program: _____
_____
_____
_____

_____ _____
Signature Date

Please check: ❍ Medical Physician ❍ Chiropractor ❍ Physical Therapist ❍ Massage Therapist
Other:_____

Please Return this form to your patient or mail to: Fitness Director
Bellingham Tennis Club & Fairhaven Fitness
800 McKenzie Ave., Bellingham, WA 98225
www.bellinghamtennis.com 360-733-5050 www.fairhavenfitness.us