

# EXERCISE PRESCRIPTION & REFERRAL FORM



PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

HEALTH CARE PROVIDER'S NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

## PHYSICAL ACTIVITY RECOMMENDATIONS

Type of physical activity:	Aerobic	Strength
Number of days per week:		
Minutes per day:		
Total minutes per week*:		

### \*PHYSICAL ACTIVITY GUIDELINES

*Adults aged 18-64 with no chronic conditions:* Minimum of 150 minutes of moderate physical activity a week (for example, 30 minutes per day, five days a week) **and** muscle-strengthening activities on two or more days a week ([2008 Physical Activity Guidelines for Americans](http://www.acsm.org/physicalactivity)). For more information, visit [www.acsm.org/physicalactivity](http://www.acsm.org/physicalactivity).

## REFERRAL TO HEALTH & FITNESS PROFESSIONAL

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Web Site: \_\_\_\_\_

Follow-up Appointment Date: \_\_\_\_\_

Notes: \_\_\_\_\_

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