Medical Referral

La Vita Office Use

Date Received: _____ Date Contacted: _____

Contacted by: _____

Contact: ◯ Verbal ◯ Phone Message

Outcome: ◯ Appt scheduled _____ ◯ Not interested

Scheduled with: _____

Today's Date: _____ Patient Name: _____

DOB: _____ Phone: _____ Email: _____

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

□ Known medical conditions:

_____

_____

□ Exercise restrictions or precautions:

_____

_____

□ Patient goals:

_____

_____

_____ _____

Referring Provider's Name (**Please Print**) Email/Phone Number

_____ _____

Signature Date

2815 New Pinery Road • Portage, WI • (608) 745-3800 • (608)-566-1571 (fax)

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