Join La Vita Transitions!

Our unique, medically-integrated program sets us apart from all other fitness centers in the Portage area. With our professional team of Strength and Conditioning Coaches and health providers at Aspirus Divine Savior, we are able to offer a fitness program specifically focused on each individual. Healthcare provider referral required.

The eight-week program is designed for individuals transitioning from, or managing a medical condition needing additional support.

Focus Areas
- Cardiac/Pulmonary
- Fit for Surgery
- Orthopedic
- Start Moving
- Diabetes
- Rehab
- Weight Management
- Pre/Postnatal

8 Week Program Layout
Initial and final assessment
Personalized workout designed in conjunction with your medical provider and La Vita Strength & Conditioning Coach
One-on-one sessions with a Strength & Conditioning Coach
Unlimited full access to La Vita during the eight-week program

Free La Vita Enrollment
for program participants who join within two weeks of completing the program.

Cost: La Vita Member $99
Non-member $129

2815 New Pinery Road, Portage, WI | 608-745-3800 | lavitafitness@aspirus.org
Medical Referral

LaVita Office Use

Date Received: ___________ Date Contacted: ___________

Contacted by: __________________________________________

Contact:  ○ Verbal  ○ Phone Message

Outcome:  ○ Appt scheduled  ○ Not interested

Scheduled with: __________________________________________

Today's Date: ___________ Patient Name: _______________________________________________

Date of Birth: ___________ 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 ______________________________