



GP MEDICAL CLEARANCE FORM FOR
"GET MOVING" GENTLE EXERCISE GROUP

Resident Name:	DOB:
Referring Professional Name:	Phone:
Physiotherapist Name (within facility): Comments (if applicable):	
Name of Residential Aged Care Facility: Fax number:	

Dear Dr. _____,

Your resident _____ would like to take part in the "GET MOVING" gentle exercise program currently being offered within our facility. It will be conducted by a qualified and registered Exercise Physiologist. There will be 2 x 30 minute sessions per week for 12 continuous weeks and 2 x 15 minute assessments (conducted at week one and twelve).

The exercise program may include progressive resistance training and flexibility exercises. The assessments will include muscular strength, endurance, agility and balance tests.

Written medical clearances are necessary for residents to participate in the "GET MOVING" gentle exercise program. The medical clearance must be from the resident's usual GP and must specify if there are any exercise limitations that should be taken into consideration. Please identify any recommendations or restrictions for your resident's participation in the "GET MOVING" gentle exercise program.

I RECOMMEND THE FOLLOWING (Please TICK selection)

I am not aware of any contraindications toward participation in this gentle exercise program.

The resident (identified above) can participate, but urge caution because:

The resident should not engage in the following activities:

I recommend the resident **NOT** participate in the above "GET MOVING" gentle exercise program.

GP Signature: _____

GP Name (print): _____

Date: _____

PLEASE FAX THIS BACK
TO THE AGED CARE FACILITY (FAX NUMBER AT TOP OF PAGE)