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COMPREHENSIVE PHYSICAL THERAPY CENTER, INC.

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**TO:** PHYSICIAN  
**FROM:** CHRISTOPHER J. KOSOBUCKI, DPT, CSCS  
**SUBJECT:** PHYSICIAN APPROVAL FOR FITNESS ASSESSMENT PARTICIPATION

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Your patient has applied for our COMPFIT Fitness Assessment program conducted by the Comprehensive Physical Therapy Center, Inc. The testing is offered to all clients. As a prerequisite of the program, we require applicants who may be at risk to obtain medical approval and written recommendations from their physicians.

All participants will be given a battery of health profile tests including an aerobic capacity test, body composition measurements, muscular strength and endurance tests and flexibility assessments.

The aerobic capacity test will consist of either a treadmill, step or field test. Determination of which test used will be gauged by the patient's level of risk and physical ability. Testing will be done at a submax level and there will not be a physician present during the fitness assessment.

A copy of all test results will be forwarded to you upon your request.

To ensure that your patient has no contraindications to exercise, we ask that you complete the brief form, which is attached. Your participation is a very important segment in our assessment program.

Thank you for your assistance. If any questions or concerns should arise, please feel free to contact me at (919) 967-5959.

Physician Recommendation Form on reverse side or follows this page if a fax transmission.



**COMPREHENSIVE PHYSICAL THERAPY CENTER, INC.  
PHYSICIAN RECOMMENDATION FORM**

Client's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)

Please check and/or explain any contraindication, which may limit your patient's activity:

	Comments/Explanation
Age: _____	
Sex: _____	
Myocardial Infarction _____	
Angina _____	
Other heart/circulatory _____	
Asthma _____	
Pulmonary Disease _____	
Diabetes _____	
Arthritis _____	
Obesity _____	
Other: _____	

List any medications that your patient is presently taking:

\_\_\_\_\_

I recommend that the following health improvement area be included in my patient's program at Comprehensive Physical Therapy Center, Inc.:

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Print Physician's Signature \_\_\_\_\_

Would you like a copy of the Fitness Assessment results:            Y            N

I authorize Dr. \_\_\_\_\_ to furnish Comprehensive Physical Therapy Center, Inc. all information concerning any medical history, treatments, examinations and hospitalizations. This information is to be used in completing the Fitness Assessment Program for patients of Comprehensive Physical Therapy Center, Inc. I understand that this information will be treated as confidential and will not be further released without my permission.

Patient's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Please return to:            Comprehensive Physical Therapy Center, Inc.  
115 Timberhill Place  
Chapel Hill, NC 27514  
Fax: (919) 968-1478 / Phone: (919) 967-5959