Physician Medical Release Form

Date _____

Doctor's Name: _____

My patient,_____DOB_____ ***who has been diagnosed with LBD, Parkinson's disease and/or a Parkinsonism***, wishes to participate in one or more of these non-contact exercise programs:

*** Rock Steady Boxing * Urban Poling * PWR! Moves for PD**

These activities will involve cardiovascular training, walking, punching heavy bags, flexibility instruction (stretching, getting up and down on the floor), resistance training and core strengthening techniques. Participants can attend up to five classes per week that are 60-90 minutes in duration. Participants can reach up to 90 percent of their maximum heart rate.

**** Speech/Swallowing Evaluation and Treatment_____(Physician initials)**

Our team of eight Speech-Language Pathologists are trained in Parkinson's specific treatment programs for Voice, Swallowing, and Cognition issues that most patients experience.

Patient's Contact Information_____

PHYSICIAN'S RECOMMENDATION

☐ I am not aware of any restrictions to participate in these exercise programs.

NOTES: _____

_____

PHYSICIAN COMPLETES

_____ has my approval to begin the Parkinson's Exercise Programs: Rock Steady Boxing, Urban Poling, PWR! Moves for PD, and/or Speech/Swallowing Eval and Treatment with the recommendations or restrictions stated above.

Physician's Printed name _____

Physician's Signature _____

RETURN TO: Carolyn Rhodes ~ Parkinson's Dynamics
FAX: 256-936-4484 PHONE: 256-513-8164

10/2023