SPEAK OUT!® Therapy Program

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. The Boxing classes 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 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, CEO, carolyn.rhodes@pyn.org
PHONE: 256-513-8164
FAX: 256-936-4484

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