St. Joseph's Healthcare Hamilton

STAY WELL PROGRAM MEDICAL CLEARANCE

Patient's Name:_____

Sent by:_____ Phone: _____

Your patient has been recommended in the Stay Well Program at St. Joseph's Healthcare Hamilton. The purpose of the Stay Well program is to maintain and improve the patient's current level of mobility and physical capabilities. It is designed for the frail elderly and includes group activities to maintain balance, flexibility, muscular strength and cardiovascular endurance. This completed form is necessary for the patient's acceptance into the program.

SPECIFIC MEDICAL INFORMATION

Blood Pressure	Resting Heart rate

SYSTEM	SPECIFIC IMPAIRMENT	COMMENTS
CARDIO/RESPIRATORY		
HEART	○ Pacemaker	
	○ M.I. (when)	
	○ Angina within 6 months	
	○ Arrhythmia	
	○ Significant valvular heart disease	
	○ Congestive heart failure	
	○ Peripheral vascular disease	
	○ hypertension	
LUNG	○ Chronic pulmonary disorder	
MUSCULOSKELETAL	○ osteoporosis	
	○ low back conditions	
	○ arthritis (include type)	
NERVOUS SYSTEM	○ stroke	
	○ dementia	
	○ balance loss	
	○ Other disorders of nervous system	
METABOLIC FUNCTION	○ diabetes	

	○ hyper/hypothyroidism	
PSYCHO-SOCIAL	○ depression/psychiatric	
	○ stress	
	○ bereavement	
	○ isolation	
OTHER	○ falls	
	○ dizziness	
	○ chronic pain	
	○ anemia	
PLEASE LIST ANY OTHER RELEVANT CONDITIONS OR CONCERNS		

Are there any side effects to medications prescribed that may affect your patient's ability to exercise under supervision?

- ○ NO
- ○ YES please explain:_____

_____

Is there any other information not covered which may be helpful in prescribing exercise to or monitoring your patient in our program?

- ○ NO
- ○ YES please explain:_____

The Stay Well program provides a light snack for its' participants. Does your patient have any swallowing difficulties or other dietary restrictions (ie; food allergies)?

- ○ NO
- ○ YES please explain:_____

_____

Based upon a current review of the documented health status of _____,
I recommend:

- ○ Participation in the Stay Well Program to maintain physical abilities
- ○ Participation in the Stay Well Program with the following recommendations:

_____

_____

- ○ No participation of any type in a supervised physical maintenance program

_____ _____

Completed by: Date:

_____ _____

Physician's Name: Physician's Signature

_____ _____

Address: Phone Number:

Locations:

Stay Well Program
SJHH – King Campus
2757 King Street East
Hamilton, ON
L8G 5E4

Stay Well Program
SJHH – West 5th Campus
Level 0 - Outpatients
100 West 5th Street
Hamilton, ON L9C 0E3

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