NeuroHope of Indiana, Inc.
6002 Sunnyside Rd.
Indianapolis, IN 46236
www.neurohopewellness.org

Medical Clearance Form

Name of Patient/Participant: _____

Patient's Consent and Authorization

I consent to and authorize Dr. _____ to release to NeuroHope of Indiana, Inc., health information concerning my ability to participate in NeuroHope's Physical Therapy and exercise programs and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Patient/ Participant Name: _____ Date: _____

Patient / Participant (or Guarantor) Signature: _____

Physician Authorization

The Participant may receive the following treatments and engage in the following programs and/or assessments:

Electrical Stimulation (Neuromuscular Re-ed, Functional)

□ Yes, with no limitations □ Yes, with limitations below □ No, cannot participate
Limitations/recommendations: _____

Full Weight Bearing/Standing (assisted or standing frame)

□ Yes, with no limitations □ Yes, with limitations below □ No, cannot participate
Limitations/recommendations: _____

General Cardiovascular Activities

□ Yes, with no limitations □ Yes, with limitations below □ No, cannot participate
Limitations/recommendations: _____

Muscular Strengthening

□ Yes, with no limitations □ Yes, with limitations below □ No, cannot participate
Limitations/recommendations: _____

Flexibility

□ Yes, with no limitations □ Yes, with limitations below □ No, cannot participate
Limitations/recommendations: _____

Muscular Endurance

□ Yes, with no limitations □ Yes, with limitations below □ No, cannot participate
Limitations/recommendations: _____

Physician Signature: _____ Date: _____