EXERCISE PRESCRIPTION & REFERRAL FORM

PATIENT'S NAME: _____ DOB: _____ DATE: _____

HEALTH CARE PROVIDER'S NAME: _____ SIGNATURE: _____

PHYSICAL ACTIVITY RECOMMENDATIONS

Type of physical activity:	Aerobic	Strength
Number of days per week:		
Minutes per day:		
Total minutes per week*:		

*PHYSICAL ACTIVITY GUIDELINES
Adults aged 18-64 with no chronic conditions: Minimum of 150 minutes of moderate physical activity a week (for example, 30 minutes per day, five days a week) *and* muscle-strengthening activities on two or more days a week (2008 Physical Activity Guidelines for Americans).
For more information, visit www.acsm.org/physicalactivity.

REFERRAL TO HEALTH & FITNESS PROFESSIONAL

Name: _____

Phone: _____

Address: _____

_____

Web Site: _____

Follow-up Appointment Date: _____

Notes: _____

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