(Date)

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_

I am reaching out in regards to a patient I’m treating at (Name of Organization)\_\_\_\_\_\_\_\_\_\_\_\_ by the name of (patient’s full name, date of birth)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive medical clearance to participate in high intensity gait training as part of his/her recovery process. His/her diagnosis is \_\_\_\_\_\_\_\_\_\_\_\_\_ with a past medical history significant for \_\_\_\_\_\_\_\_\_\_\_\_.

High intensity gait training consists of challenging the patient using the FITT (Frequency, Intensity, Time, Type) principle, including reaching 75-85% of heart rate max or 70-80% heart rate reserve. Therefore, (patient’s name) heart rate target range will be (HR range) . The heart rate and BORG rating of perceived exertion scale will quantify the intensity and will be monitored closely.

Current research shows that high intensity gait training improves overall gait speed, paretic limb stance time, muscular and cardiovascular endurance, and improved dynamic balance. By challenging the neurologic and cardiovascular systems, high intensity gait training increases neuroplastic changes and improved functional recovery compared to standard physical therapy interventions.

Specifically, for (patient’s diagnosis) the following research studies have been completed demonstrating high intensity gait training to be effective and that there is no difference in adverse events compared to conventional therapy. If you are interested, I can provide you with a list of research articles*.*

Based on \_\_\_\_\_\_\_\_\_\_ (patient’s name) diagnosis and current level of functional recovery it appears he/she is a good candidate for moderate to high intensity gait training to improve walking ability. I have reviewed the patient’s past medical history, medications, and precautions thoroughly. All vitals will be monitored before, during, and after the training session in accordance with the American College of Sports Medicine’s guidelines for cardiac patients. The session will be stopped immediately if the patient demonstrates any adverse effects.

We will proceed with providing (patient’s full name, date of birth)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ high intensity gait training which will involve gait training at potentially aerobic intensities (75-85% of heart rate max or 70-80% heart rate reserve) unless otherwise indicated by the physician (please see below).

Please do not hesitate to reach out to me with any questions at (phone number) ext. \_\_\_\_\_\_\_\_\_\_\_.

Thank you,

 Therapist Name

Title

Phone number

e-mail

Address

**Medical Clearance**

(patient’s full name, date of birth)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_is cleared for moderate intensity gait training, with a heart rate range of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_\_\_\_

Please return this form to:

fax (enter fax number) attn:

or

email to (enter email address)