Sargent Health Fitness Plan

For Use Upon Discharge From Physical/Occupational Therapy

Name of Participant: _____

Name of Therapist: _____

Thank you for your interest in the Sargent Health Fitness Plan. This form was created by Boston University College of Health and Rehabilitation Sciences: Sargent College (Sargent College) and is intended to be used by physical therapists (PTs) or occupational therapists (OTs) to outline appropriate exercises for their clients. This form serves two purposes:

it can be used to indicate appropriate exercises for an individual upon discharge from PT/OT services; and
it can help facilitate communication between the PT/OT and the individual's health fitness professional.

INSTRUCTIONS

TO THE CLIENT: This form is intended to be utilized to outline appropriate exercises based on your *current* health status. If you experience a change in your health status, these recommendations may no longer be valid and you should take appropriate action. That means it is up to you to seek out further medical attention either from your primary care physician or any other specialist that is needed. We recommend that you sit down with your physical or occupational therapist and outline an appropriate fitness plan designed specifically for you by checking off the relevant boxes on the form. Please note, this form will be used to report and share with an appropriate health and fitness facility any pertinent medical issues that may affect your participation in an exercise program or activity. If you have any questions or concerns, please discuss them with your therapist.

TO THE THERAPIST: Please fill out this form in consultation with your client by checking only the relevant boxes for the participant. Consider educating your client with regard to indications for returning to a PT/OT professional. Examples may include 6-month brace re-evaluation, anticipated wheelchair modifications for seating clinic, increased activity tolerance, etc. A medical clearance should be received from a medical doctor to clear the individual to participate in FES and/or a Standing Frame program. If you know of any medical or other reasons why participation in an exercise program by the applicant would be unwise/unsafe, please indicate so on this form. *For your convenience, equipment that does not require a transfer have been marked as depicted.*

Participant is responsible for entering the gym independently OR

with one's own personal assistant (PCA, family)

By using this form, you (Client and Therapist) agree to release Boston University (including Sargent College), its officers, directors, employees and agents from any liability arising out of, or in connection with, your use of this form. In no event will Boston University, its officers, directors, employees or agents be liable for indirect, special, consequential, or punitive damages, even if those damages are otherwise foreseeable or even if any of them have been advised of the possibility of such damages.

Participant or Caregiver should bring completed form to appropriate exercise facility

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Sargent Health Fitness Plan

Name: _____

Mobility Level: Ambulatory: Y / N (Distance:_____) **Wheelchair User: Y / N Community Assistance Level**_____

Estimated or Actual Height and Weight: _____ **Household assistance level**_____

Participant educated on HR and BP assessment for exercise: Y / N Waist Circumference: Sitting: _____

WHEELCHAIR ACCESSIBLE

☐ **Chest Press**

☐ **Overhead Press**

☐ **Lat Pulldown**

☐ **Compound Row**

☐ **Functional Trainer**
(indicate ROM if appropriate):

- ☐ Shoulder Flex/Ext
- ☐ Elbow Flex/Ext
- ☐ Shoulder Abd/Add
- ☐ Hip Flex/Ext

☐ Rope Climber

Additional Equipment

Cuffs, Hooks, Gloves, Chest Strap, Velcro Straps, Adaptive Bike Peddle, Theraband, Free Weights, Cuff Weights, Leg guides

Other Relevant Information/Contraindications:

_____

_____

Potential Participant Health/Fitness Goals:

☐ Increase Endurance ☐ Increase Strength ☐ Skin Integrity
☐ Weight Loss ☐ Increase Flexibility ☐ _____
☐ ↑ Resting BP ☐ ↓ Resting BP _____

Indications for Return to Healthcare Provider:

☐ Safety: _____
☐ ↑↓ in status (pain, strength, function, etc.): _____
_____
☐ Brace Re-eval : _____
☐ Other _____

☐ **Vita glide**

☐ **Reck MOTOmed**
☐ Arms ☐ Legs

☐ **RT 300-S* FES Bike**
Muscle Stimulated:
☐ Glutes
☐ Hamstrings
☐ Quadriceps
☐ Gastroc/Soleus
☐ Anterior Tibialis

If applicable:
ID #:_____
Password:
_____

☐ **Arm Ergometer**

☐ **Cybex Bravo Functional Trainer**

PT/OT Signature indicates ONLY non-transfer activity appropriate: _____ **Date**:_____

Equipment listed below and on next page *require transfers* Level of Assist with Transfers: _____

☐ **Self-stretching Mat Table Exercises**:
_____
_____
_____

☐ **Easy Stand 6000 Glider* Stander**

☐ **NuStep T5XR Recumbent Cross Trainer**

☐ **Concept 2 Model E Rower**

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Level of Assist with Transfers: _____

ARMS/CHEST/BACK

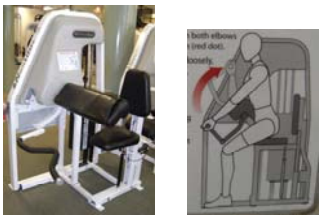
☐ **Keiser bilateral Upperback**

☐ **Incline Press**

☐ **Keiser Bilateral Chest press**

☐ **Overhead Press**

☐ **Pec Fly**



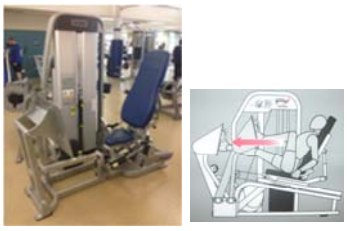
☐ **Preacher Curl**

☐ **Triceps Press**

Exercises:
- ☐ Supination
- ☐ Pronation
- ☐ Wrist Flexion
- ☐ Wrist Extension
- ☐ Grip Strength

☐ **Super Forearm**

LEGS



☐ **Leg Press**

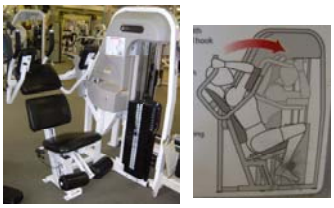
☐ **Hip Abduction/Adduction**

☐ **Leg Extension**

☐ **Seated Leg Curl**

TRUNK

☐ **Lateral Raise**



☐ **Abdominal**

☐ **Lower Back**

Other Relevant Information (BP/HR Targets, Recommendations for Brace/Assistive device use while in the gym, Brace or Assistive Device Re-evaluations, Additional Equipment considerations, etc.):

PT/OT Signature: _____ Date: _____

All Photos Taken at the Quincy Branch South Shore YMCA

Participant or Caregiver should bring completed form to appropriate exercise facility