Community Exercise Programme for Stroke
Physician Consent Form

Dear Doctor:

Your patient _____wishes to participate in a Community-based Exercise Programme for People Living with Stroke. This programme will occur twice weekly for 8 weeks. Each session will be 60 minutes in total, and will include a 10 minute warm-up and stretching component, 20 minute strengthening and aerobic fitness component, 10 minute balance and mobility component, and a 5 minute cool-down. The intensity will be gradually increased to a moderate to somewhat strong intensity (i.e. able to still converse comfortably with little effort).

By completing this form, you are not assuming any responsibility for the exercise. However, this information will help us to determine whether your patient is safe to participate in the programme.

I consent to and authorize _____ to release to_____ relevant health information concerning my stroke and my ability to participate in the exercise programme. Authorization is not valid beyond 6 months from the date of signature. Further disclosure of release of my health information is prohibited without specific written consent of person to whom it pertains.

Participant signature :	Date:
Health Care Link signature:	Date:

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Please complete the following information:

Date of Stroke (dd/mm/yyyy)		
Type of Stroke (please check)	Ischemic ☐	Hemorrhagic ☐
Location of Stroke		
Please check if the client has any of the following contraindications to our programme:		
☐ Presence of an unstable medical condition		
☐ Presence of a disorder (other than stroke) that may affect balance (i.e. head injury, vestibular dysfunction or severe peripheral neuropathy)		
☐ Musculoskeletal contraindications to exercise	☐ Presence of dementia	

Physician Recommendations (please check 1 box)

	I am not aware of any contraindications toward participation in this programme.
	I believe the applicant can participate, but urge caution because:
	The applicant should not engage in the following activities:
	I recommend the applicant **NOT** participate in the above exercise programme.

Physician signature:	Date:
Physician name (print):	
Address:	