REFERRAL FOR EXERCISE REHAB

NAIROBI FITNESS CONSULTING

8th Flr, Western Heights, Karuna Rd, Westlands
P.O. BOX 66828 - 00800, Nairobi, Kenya
Tel: +254 725 251930

Surname: _____ First Name: _____

Other Names: _____ Age: _____ Sex: _____

DIAGNOSIS: _____

RELEVANT MEDICAL HISTORY: _____

_____

TREATMENT REQUIRED:

- ☐ Reduce risk of heart disease
- ☐ To assist with autoimmune disease
- ☐ Reduce risk &/ or improve management of diabetes
- ☐ Combat symptoms of anxiety and depression
- ☐ Chronic obstructive pulmonary disease
- ☐ Improve cardiovascular fitness
- ☐ Improve cholesterol and dyslipidemia
- ☐ Improve blood pressure
- ☐ Fit for surgery
- ☐ Post-operative rehab
- ☐ Chronic fatigue
- ☐ Neuromuscular fitness
- ☐ Orthopedic fitness
- ☐ Pulmonary fitness
- ☐ Metabolic syndrome
- ☐ Muscle wasting
- ☐ Reduce risk of cancer
- ☐ Reduce risk of cognitive decline
- ☐ Reduce fatigue & improve sleep quality
- ☐ Improve pain management
- ☐ Reduce fall & fracture risk
- ☐ Increase bone density
- ☐ Prevent & rehab cachexia muscle wasting
- ☐ Improve symptoms of eating disorders
- ☐ Substance addiction aftercare
- ☐ Weight management
- ☐ Hormone resistance
- ☐ Inactive to active
- ☐ Functional fitness
- ☐ Treatment aids & equipment
- ☐ Other:

Includes pre-training & post-training measurements, individual exercise prescription, progress report to health care provider, >12-week membership and thrice per week supervised training.

DOCTOR'S NAME: _____ DATE: _____

SIGNATURE: _____