

## Health Fitness Plan

*For Use Upon Discharge From Physical/Occupational Therapy*

Name of Participant: \_\_\_\_\_

Name of Therapist: \_\_\_\_\_

Instructions: Thank you for utilizing the Health Fitness Plan. This form serves two purposes. First, this form will be used to indicate appropriate exercises for you upon discharge from PT/OT services and secondly, to facilitate communication between the PT/OT and local health fitness professional.

TO THE CLIENT: This form is intended to be utilized to outline appropriate exercises based on your *current* health status and based on what we know now. If you experience a change in your health status, these recommendations may no longer be valid and you must 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. Please be advised that the PT/OT will **not** be continuing on in your care upon discharge from our facility. 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 HFP form.

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. By completing this Health Fitness Plan, you are not assuming any responsibility for administration of the exercise 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)*



NOTE TO THERAPIST: A medical clearance should be received from a medical doctor to clear the individual to participate in FES and/or a Standing Frame program.

I, \_\_\_\_\_ (Name of Participant), give my Therapist permission to report per this form and subsequently share with an appropriate health and fitness facility (not just the YMCA), any pertinent medical issues that I have that may affect my participation in any exercise program or activity.

Signature of Participant \_\_\_\_\_

Date: \_\_\_\_\_

Signature of PT/OT \_\_\_\_\_

Date: \_\_\_\_\_

*Participant or Caregiver should bring completed form to appropriate exercise facility*

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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



☐ Vita glide



☐ Reck MOTomed



☐ RT 300-S\* FES Bike

Muscle Stimulated:

- ☐ Glutes
- ☐ Hamstrings
- ☐ Quadriceps
- ☐ Gastroc/Soleus
- ☐ Anterior Tibialis

If applicable:

ID #: \_\_\_\_\_

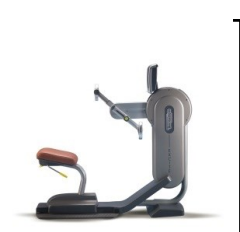
Password: \_\_\_\_\_



☐ Lat Pulldown



☐ Compound Row



☐ Arm Ergometer



☐ Arms ☐ Legs ☐



☐ Functional Trainer



☐ Rope Climber

(indicate ROM if appropriate):

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

**Adaptive Equipment:** Cuff, Hooks, Gloves, Chest Strap, Velcro Straps, Adaptive Bike Peddle, Theraband, Free Weights, Cuff Weights, Leg

## Other Relevant Information/Contraindications:

\_\_\_\_\_  
\_\_\_\_\_

## 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 \_\_\_\_\_

PT/OT Signature indicates ONLY non-transfer activity appropriate: \_\_\_\_\_ Date: \_\_\_\_\_

Equipment listed below and on next page *require transfers*

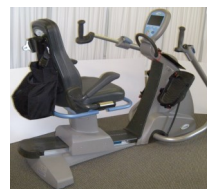
Level of Assist with Transfers: \_\_\_\_\_



☐ Mat Table Exercises: \_\_\_\_\_



☐ Easy Stand 6000 Glider\* Stander



☐ NuStep T5XR Recumbent Cross Trainer



☐ Concept 2 Model E Rower

Level of Assist with Transfers: \_\_\_\_\_



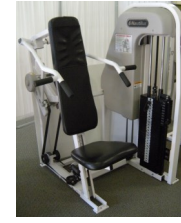
☐ Keiser bilateral Upperback



☐ Incline Press



☐ Keiser Bilateral Chest press



☐ Overhead Press



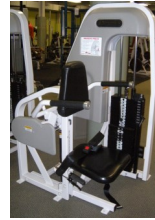
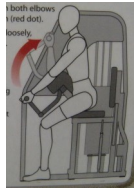
ARMS/CHEST/BACK



☐ Pec Fly



☐ Preacher Curl



☐ Triceps Press



☐ Super Forearm

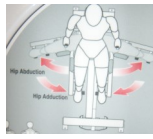
- Exercises:
- ☐ Supination
  - ☐ Pronation
  - ☐ Wrist Flexion
  - ☐ Wrist Extension
  - ☐ Grip Strength



☐ Leg Press



☐ Hip Abduction/Adduction



☐ Leg Extension



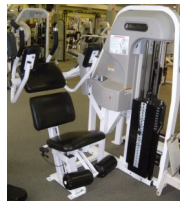
☐ Seated Leg Curl



LEGS



☐ Lateral Raise



☐ Abdominal



☐ Lower Back



TRUNK

Other Relevant Information (Aquatics, BP/HR Targets, Brace/Assistive device use during exercise, Additional Equipment, etc.):

PT/OT Signature: \_\_\_\_\_ Date: \_\_\_\_\_