Fitness and Mobility Exercise Program (FAME)
Screening and Consent Form

Part 1:

Demographics			
Name:		Age:	☐ Male ☐ Female
Address:		Postal Code:	
E-Mail Address:		Date of Birth (dd/mm/yy):	
Phone (Home):	(Work):	(Cell):	
Person to contact in case of emergency:		Phone:	
Physician's Name:		Phone:	

Information on Stroke		
Date of Stroke (dd/mm/yy)		
Post-Stroke Impairments	☐ Left Sided Weakness ☐ Right Sided Weakness ☐ Communication ☐ Shoulder Pain	☐ Memory ☐ Attention ☐ Perception ☐ Vision
Assistive Devices	☐ Ankle Foot Orthosis (AFO) ☐ Cane	☐ Shoulder Brace/Sling ☐ Walker

Other Medical Conditions		
☐ Osteoarthritis of the	☐ Knee ☐ Ankle	☐ Hip ☐ Other
☐ Cardiovascular Condition	☐ Congestive Heart Failure ☐ Heart Attack ☐ Heart Surgery ☐ Arrhythmia	☐ High Blood Pressure ☐ Valve Disease ☐ Angina ☐ Other:
☐ Diabetes	☐ Type 1 (Insulin Dependent)	☐ Type 2 (Adult Onset)
☐ Osteoporosis	☐ Other:	

Safety – Risk of Falls		
☐ Low Risk	☐ Intermediate Risk	☐ High Risk
Increased supervision needed with the following exercise activities:		
Consent to contact:		

Part II: Medical Screening

Has a physician ever said you have a heart condition and you should only do physical activity recommended by a physician?	☐Yes	☐No
When you do physical activity, do you feel pain in your chest?	☐Yes	☐No
When you were not doing physical activity, have you had chest pain the past month?	☐Yes	☐No
Do you ever lose consciousness or do you lose your balance because of dizziness?	☐Yes	☐No
Do you have a joint or bone problem that may be made worse by a change in your physical activity?	☐Yes	☐No
Is a physician currently prescribing medications for your blood pressure or heart condition?	☐Yes	☐No
Have you been diagnosed with Osteoporosis or had any fractures?	☐Yes	☐No
Do you have any lung or breathing problems?	☐Yes	☐No
Do you have insulin dependent diabetes?	☐Yes	☐No
Do you know of any other reason you should not exercise or increase your physical activity?	☐Yes	☐No

If you answered **YES** to any of the above questions, talk with your doctor BEFORE you participate in a fitness test or become substantially more physical active. Tell your doctor your intent to exercise and to which questions you answered yes. If you answered NO to all questions you can be reasonably positive that you can safely increase your level of physical activity gradually.

Signature:	Date:

Part III: Informed Consent

FAME is a group exercise program developed for people with stroke who have some standing and walking ability. I am knowledgeable of the program components, which include warm-up exercises, functional strengthening, balance, flexibility and agility, and cool-down activities. I understand the purpose of the FAME program and desire to improve my motor function (muscle strength, balance, mobility), cardiovascular fitness, and executive functioning as a result of participating in the FAME program. I understand that I am responsible for monitoring my own condition throughout the program and should any unusual symptoms occur (pain, dizziness, nausea), I will cease my participation and inform the instructor of any symptoms, injuries or illnesses.

In the event that a medical clearance must be obtained prior to my participation, I agree to consult and obtain written permission from my physician before commencing.

By signing this consent form, I assume all the risks of injury, loss, or expense of any kind resulting from my participation in the program. I will not hold the Richmond Fitness and Wellness Association, City of Richmond or the staff associated with the program, liable for any injury, loss, or expense suffered as a result of my participation. This release will apply to each and every session that I participate in the program.

I have read, understood, and fully agree to the foregoing. Any questions I had have been answered to my satisfaction.

Signed on the _____ day of (month) _____ , 20_____

By:_____ _____

(Participant's Signature) (Printed Name)

Part IV: Physician Consent of Referral

Your patient wishes to participate in the Fitness and Mobility Exercise Program (FAME) for people with stroke. This program will include a 5 minute warm-up, 15 minute functional strengthening (e.g., repetitive sit-to-stand), 15 minutes fitness and agility (e.g., step ups while holding onto support), 15 minute balance component (e.g., standing and reaching) and a 5 minute stretching component. The classes run two times a week over an 8 to 12 week period. The intensity will be gradually increased to a moderate intensity at 60% of age-predicted heart rate maximum (i.e., fairly light to somewhat hard effort).

Physician's Recommendation (please check box)

I authorize the applicant to participate in the FAME program

☐ I am NOT aware of any contraindications toward participation in this program
☐ 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 FAME program

_____ _____
Physician's Signature Physician's Name (printed)

Contact Number: _____ Date: _____

This information will help us determine whether your patient is appropriate for the program.
When completed, please fax this form to: ***Attention: Danny Ronquillo***
Fitness and Wellness Leader
Fax number: 604-718-8462