OLD DOMINION
UNIVERSITY
IDEA FUSION

Department of Human Movement Sciences
Student Recreation Center, Suite 2006
Norfolk, Virginia 23529-0196
Phone: (757) 683-4995 Fax: (757) 683-4270

Dear Friend in Health:

Thank you for your interest in the T.E.M.P.O. therapeutic exercise program at Old Dominion University. Exercise has many benefits, and I am glad you have chosen to adopt an active lifestyle as part of your long-term health care.

To participate in the program, please provide us with a signed copy of the informed consent form and medical history questionnaire that are attached to this letter, and return to the TEMPO coordinator.

In addition, please fill out the "Participant's Authorization for Release of Medical Information Form", which is the second page in the Physician's Information Packet, and give that packet to your physician. Your physician will need to send us your most recent medical history.

I look forward to working with you. If you have any questions, please call me at 683-4974, or the TEMPO Graduate Assistant, Rylie Hughes at 683-6407.

Sincerely,

Leryn Reynolds, Ph.D.
Director, Wellness Institute & Research Center
Associate Professor, Exercise Science
Student Recreation Center RM 1006C
Old Dominion University
Norfolk, VA 23529-0916
(757) 683-4974
Lreynold@odu.edu

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INFORMED CONSENT FOR EXERCISE THERAPY

I desire to engage voluntarily in the TEMPO therapeutic exercise program at Old Dominion University, in order to improve or maintain my cardiovascular fitness.

The program will follow an exercise prescription prepared by the director of the Wellness Institute and Research Center and/or my physician and will be carefully followed by the staff of the exercise program. The exercise prescription will be based upon my clinical evaluation. I agree to comply with the exercise prescription that I am given.

The activities that I will be given are designed to place a gradually increasing work load on the circulatory system and thereby improve its function. I understand that the reaction of the cardiovascular system to such activities cannot be predicted with complete accuracy. There is the risk of certain cardiovascular changes occurring during or following the exercise session. These changes may include abnormalities of blood pressure or heart rate, ineffective heart function, and in rare instances, fatal or nonfatal heart attack, stroke, or cardiac arrest. There is also a risk of musculoskeletal injury from such exercise.

I understand that it is my responsibility to follow the instruction of the staff regarding the type and intensity of exercise performed in the program. It is also my responsibility to inform the staff of any symptoms I may experience prior to, during, or after an exercise session. I understand that it is my responsibility to report to the staff any changes in my usual medications. I will report to the staff if I have to leave the exercise session early. I agree not to leave the exercise area without a cool-down period during which my heart rate has returned to its pre-exercise rate.

I understand and accept the risks posed by this therapeutic exercise program. I will not hold Old Dominion University or the personnel of the Wellness Institute and Research Center liable for any injury or illness that I might encounter as a result of this program.

I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

Participant Signature:_____ Date:_____

Witness: _____

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Medical History Questionnaire

Directions. The purpose of this questionnaire is to enable the staff of the Wellness Institute and Research Center to evaluate your health and fitness status. Please answer the following questions to the best of your knowledge. All information given is **CONFIDENTIAL.**

Name:_____ Age:____ Date of Birth: _____
Work Address: _____
Home Address: _____
Work Phone: _____Home Phone: _____ SS# _____

Name and Address of Your Physician: _____
_____
Name of person to contact in case of emergency: _____
Phone Number: _____ Relationship: _____

Medical History

Do you have or have you ever had any of the following conditions? (Please write the date when you had the condition in the blank).

____ Heart murmur, clicks, or other cardiac findings?
____ Frequent extra, skipped, or rapid heartbeats?
____ Chest pain or angina (with or without exertion)?
____ Pregnancy (at present)?
____ Diagnosed high blood pressure?
____ Heart attack or any cardiac surgery?
____ Leg cramps (during exercise)?
____ Chronic swollen ankles?
____ Varicose veins
____ Frequent dizziness/fainting?
____ Musculoskeletal/Orthopedic problems
____ Diabetes?
____ Asthma?
____ Bronchitis?
____ Cancer?
____ Stroke?
____ Emphysema?
____ Epilepsy?
____ Rheumatic Fever?
____ Scarlet Fever?
____ Chronic back pain?
____ Pneumonia?
____ Blood Clots?

Do you have or have you been diagnosed with any other medical condition not listed?
_____

Please list any recent surgery (i.e., type, dates etc.)_____

Please list any allergies you may have._____

List all prescribed or non-prescribed medications that you currently take._____
_____
_____

What was the date of your last complete medical exam?_____

Are you currently experiencing any new health problems? If so, please explain._____
_____

Do you know of any medical problem that might make it dangerous or unwise for you to participate in vigorous exercise?_____ If yes, please explain.
_____

Family History

Indicate the age of diagnosis and relationship (i.e., brother, sister, father, mother) of your immediate family members who have had any of the following conditions:

Condition	Relation(s)	Age(s)
Cardiovascular Disease		
Hearth Attack		
Stroke		
High Blood Pressure		
Diabetes		
High Cholesterol		
Overweight/Obesity		

Health Inventory

Height (in) _____ Weight (lbs) _____ Weight at age 21 (lbs) _____

What is the most you have ever weighed (lbs)? _____ What was your age? _____

Do you currently follow a special diet or weight reduction program? If so, explain:
_____

What was your most recent resting blood pressure? _____

Please indicate your normal daily intake of the following:

Coffee (cups) _____ Tea (cups) _____ Sodas (12 oz serving) _____

Alcohol (number of beer, glasses of wine, and/or 1 oz drinks) _____

Cigarettes (packs/day and packs/week) _____

If you smoke, how long have you smoked? _____

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Exercise History

Please provide information regarding your current exercise routine:

Number of exercise sessions per week? _____
Duration of each exercise session _____
What is your approximate heart rate maintained? _____
What type of exercise do you do? _____
What type of exercise do you enjoy?_____

Do you exercise on a regular basis outside of the TEMPO program (if so, please describe)?
_____
_____

Social Information

Please circle you current marital status:

Single Married Divorced Widowed Separated

With whom are you currently living? _____

Do you have any children? Yes ____ No _____

What hobbies do you enjoy? What do you do to relax? _____
_____

What in life is most important to you? _____
_____

Goals and Education

What have you accomplished through this exercise program? _____
_____

What would you like to accomplish in the future as a participant in this exercise program?
_____
_____

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PHYSICIAN'S PACKET

Dear Physician:

Your patient has expressed interest in participating in the TEMPO therapeutic exercise program at the Wellness Institute and Research Center at Old Dominion University. TEMPO is for stable, non-symptomatic patients with heart disease, or other chronic conditions such as diabetes mellitus, chronic obstructive pulmonary disease, Parkinson's Disease etc. (see the attached criteria). Our facility offers supervised exercise training including: treadmill walking, bicycle ergometry, arm ergometry/rowing and strength conditioning, and the exercise sessions are supervised by an exercise physiologist. Blood pressure monitoring is performed, and an automated external defibrillator is on site.

Please review and sign the "Physician's Permission Form, and send it to us with the patient's most recent information such as the medical history, laboratory results and exercise history. In addition, please provide any guidelines you wish us to follow for your patient's exercise.

If you have any questions please feel free to contact me at 683-4974. I would also like to invite you to visit our facility located in the Student Recreation Center (room 1006) at ODU. Thank you for your participation in the continued good health of your patient.

Sincerely,

Leryn Reynolds, Ph.D.
Director of Wellness Institute and Research Center
Student Recreation Center RM 1006C
Old Dominion University
Norfolk, VA 23529-0916
(757) 683-4974

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Participant's Authorization for Release of Medical Information Form

Physician's Name and Address:

_____
_____
_____
_____
_____

I, _____, hereby authorize the above named physician or facility to send specified information concerning me to:

Leryn Reynolds, Ph.D.
Director of Wellness Institute and Research Center
Student Recreation Center RM 1006A
Old Dominion University
Norfolk, VA 23529-0916
(757) 683-4974

The information shall include the following:

Medical History
Laboratory Results
Exercise History

The purpose of this information is to obtain my most recent medical history to aid in formulating my exercise prescription as a member of the TEMPO therapeutic exercise program.

I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

This authorization and request is fully understood and is made voluntarily on my part.

Participant's Signature_____ Date:_____

Witness:_____

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Therapeutic Exercise Program Entrance Criteria

1. Functional capacity – The patient should have at least a 6 MET capacity, which will allow a safe range of metabolic reserve during sustained activity of 3 or more METS (equivalent to normal walking).

2. *Medical Status – The medical status of the patient should be stable. The following criteria should be met:

   a. Normal hemodynamic responses to exercise including appropriate increases in blood pressure.

   b. Normal or unchanged ECG at peak exercise with normal or unchanged conduction, dysrhythmias stable or absent, and a stable or medically acceptable ischemic response.

   c. Stable or absent angina pectoris.

   d. Stable and/or controlled resting heart rate and blood pressure (i.e., ≤ 90 bpm and 140/90 mmHg).

   ***Note: If a stress test was not determined to be medically necessary/appropriate for the patient, then 2a and 2b may be omitted by the physician for entrance into the program.**

   _____ Physician's Initial here if omitting 2a and 2b.

3. General Fitness – The patient should have an adequate level of physical fitness (i.e. muscular strength, endurance, and body composition) for daily activities and/or occupation.

4. The patient should demonstrate the ability to self-regulate his/her exercise and recognize signs and symptoms of exercise intolerance.

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PHYSICIAN'S PERMISSION FORM

Physician: _____

Address: _____

_____

I hereby authorize my patient, _____, to participate in the Wellness Institute and Research Center's TEMPO therapeutic exercise program located at Old Dominion University. Any further considerations regarding this patient's exercise are listed below:

_____

_____

_____

_____

Physician's Signature:_____ Date:_____

Please send this form and other relevant information such as medical history, laboratory results, and exercise history to:

Leryn Reynolds, Ph.D.
Director of Wellness Institute and Research Center
Student Recreation Center RM 1006c
Old Dominion University
Norfolk, VA 23529-0916
(757) 683-4974