



THE CROCUS FOUNDATION

Survivorship Program Exercise Prescription

Today's Date ____/____/____
Medical Supervisor _____

Assigned Trainer
Reagan Friend, M.S. of Cancer Care '22
480-268-5497
reaganf.volv@gmail.com

340 E 12th St.
Dubuque, IA 52001
563-556-6496
volvfitness@gmail.com

General Information	
Patient Name:	DOB:
Phone:	Email:
Primary Health Care Provider:	

Treatment Summary	
Cancer Type:	Clinical Stage:
Surgeries:	Surgery Date(s) (Year):
<input type="checkbox"/> Radiation	<input type="checkbox"/> Lymphnode Removal
<input type="checkbox"/> Other Therapies	Type(s)

Current Drugs/Prescriptions		
Name	Side Effects	Other Notes

Other Comments/Notes:

Risk Assessment		
Fill out the information below regarding the medical status of patient at the time of entry to the program. This risk assessment will be used for Reagan to begin her physical assessment.		
Date: _____		
1. Patient currently participates in exercise?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Metabolic, CV or other Disease Present	Yes <input type="checkbox"/>	No <input type="checkbox"/>
List: _____		
- Disease is asymptomatic	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Medical clearance is recommended	Yes <input type="checkbox"/>	No <input type="checkbox"/>
*Medical clearance necessary for non-participant with symptomatic disease		
Trainer use only		
Participation Level:	1	2 3
Exercise Level:	Beginner	Experienced