YMCA Healthy Heart – Maintenance Program
Physician Clearance Form

The YMCA Healthy Heart program now offers a Maintenance class for participants who prefer in-person programming and whose health has been deemed to be stable enough that they do not require medical oversight while exercising.
This YMCA Healthy Heart Maintenance program offers:

- two in-person group fitness classes per week run by a Healthy Heart Exercise Leader (with no medical supervision) at the Bettie Allard YMCA in Coquitlam

Your patient has indicated to us that s/he would be interested in attending this non-medically managed program. The goals of this program are:

- To provide a transition between medically-supervised exercise programs to self-managed, unsupervised exercise opportunities in the community.
- To provide an opportunity for participants to continue to participate in a structured exercise class with a knowledgeable Exercise Leader experienced in working with this population
- To provide continued support and social connection for participants with a group of peers who are also living with cardiovascular disease
- To continue to encourage and support on-going healthy living behaviors through the direct expertise of our Exercise Leaders as well as through monthly Healthy Heart program e-newsletters and various free, educational participant events (such as our quarterly Healthy Heart e-webinars).
- To provide an ongoing opportunity for participants to enjoy this kind of structured exercise programming on an ongoing basis as there are no time limits for involvement, providing there are no health contraindications for participation.

To ensure your patient is appropriate and safe to participate in this exercise program, we require medical clearance. Please complete the following:

Patient Name:_____

DOB:_____ **PHN:**_____

Address:_____

Tel:_____ **Email:**_____

PHYSICIAN'S RECOMMENDATIONS:
□ I confirm that this patient is medically suitable to participate in this non-medically managed exercise program.

Please advise us if there are any restrictions or limitations for this patient:

_____

Physician Name:_____Signature:_____

Date: _____