City of Richmond

Heart Wellness Screening and Consent Form

Community Services Division
Garratt Wellness Centre

Part I: General

Name:_____ Program:_____

Today's Date:_____ Birth Date (DD/MM/YYYY):_____

Home Address:_____ Postal Code:_____

Home Phone:_____ Work:_____ Other:_____

Email Address:_____

Person to contact in case of emergency:_____ Phone:_____

Physician's Name:_____ Office Phone:_____

How did you find out about this program?_____

Does your physician know that you are taking this program? ☐ Yes ☐ No

Part II: Medical Screening

1. **Do you have heart problems?** ☐ **No** ☐ **Yes** *If yes, answer the following:*
   - Congestive Heart Failure? ☐ No ☐ Yes When:_____
   - Heart Attack? ☐ No ☐ Yes When:_____
   - Angina Pectoralis *(chest pain with activity)*? ☐ No ☐ Yes
   - Angiogram? ☐ No ☐ Yes When:_____
   - Angioplasty? ☐ No ☐ Yes When:_____
   - Arrhythmias *(irregular heart beat)*? ☐ No ☐ Yes
   - Intermittent Claudication? ☐ No ☐ Yes
   - High Blood Pressure *(hypertension)*? ☐ No ☐ Yes
   - Cardiac Related Surgery? ☐ No ☐ Yes
     Describe:_____
   - Stroke? ☐ No ☐ Yes
   - History of breathing or lung problems *(Asthma or COPD)*? ☐ No ☐ Yes
     Explain:_____
   - Other? ☐ No ☐ Yes
     Explain:_____
2. **Do you have any of the following?**
   - Muscle or joint disorders? ☐ No ☐ Yes
     Describe:_____

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- Arthritis? ☐ No ☐ Yes
  Type of arthritis and areas affected: _____
- Osteoporosis? ☐ No ☐ Yes
  Areas affected: _____
- Back pain? ☐ No ☐ Yes
  What was the diagnosis? _____
- Back Surgery? ☐ No ☐ Yes
  Explain: _____
- Hernia or condition that may be aggravated by lifting weights? ☐ No ☐ Yes
  Explain: _____
- Thyroid condition? ☐ No ☐ Yes

3. Additional questions:

- Do you currently smoke? ☐ No ☐ Yes
- Are you physically active? ☐ No ☐ Yes
  Describe: _____
- Do you ever experience loss of balance or dizziness? ☐ No ☐ Yes
  Describe: _____
- Are you currently overweight/obese? ☐ No ☐ Yes
  Explain: _____

4. List all diagnosed medical conditions and prescribed medications.

5. Do you have any other medical conditions or concerns?

Part III: Informed Consent

I understand that the Richmond Heart Wellness Program will provide me with a physical activity program that will include activities that target the cardiovascular system and will progressively increase in intensity over time. I understand that the reaction of the system to such activities cannot always be predicted with complete accuracy and therefore there is a risk associated with exercising. I also understand and accept that these risks may occur during or following an exercise session. I understand and accept the risks of participating in physical activity, including the risks resulting from my participating in the Richmond Heart Wellness Program, and that I may suffer personal injury while participating in the program.

By signing this release, 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 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: Consent of Referral – Physician or Cardiologist

(Complete the following or attach a copy of patient discharge summary)

Date:_____

Risk stratification for exercise: ☐ Low ☐ Moderate ☐ High

Recommended target heart rate:_____ Rate of perceived exertion:_____ /10

Hypertension: ☐ No ☐ Yes Blood pressure:_____ Date:_____

A1C:_____ Date:_____

Lipid profile: Total:_____ HDL:_____ LDL:_____ Triglycerides:_____

VLDL:_____ Cholesterol:_____

Exit Exercise Stress Test Date:_____ ☐ Modified Bruce ☐ Bruce Protocol Time:_____

Current BMI:_____

Identify any recommendations or restrictions for your patient's fitness program below:

☐ This patient is medically stable and safe to continue in the Richmond Heart Wellness Program.

☐ I recommend avoidance of _____.

☐ Unrestricted physical activity, start slowly and build up gradually.

I consider my patient _____, to be a reasonable candidate for the Richmond Heart Wellness Program. Further, I understand this is a community wellness program without medical supervision, which is suitable for my patient.

_____ _____
Physician's Signature Print Name

_____ _____
Cardiologist's Signature Print Name