Date of Surgery:		
Date Scheduled:		
THR:	Right:	Left:
TKR:	Right:	Left:

Screening Questionnaire & Consent Form for Joint Replacement Programs

Name: ______________________ **Date:** ______________

Birthdate (DD-MM-YY)**:** ____________ **Sex** (M/F)**:** ______ **E-Mail Address:** ______________

Home Phone: ____________ **Work:** ____________ **Other:** ____________

Person to Contact in Case of Emergency: ______________ **Phone:** ____________

Physician's Name: ______________________ **Office Phone:** ____________

A YES answer to one or more of the following questions requires medical clearance before proceeding with JR2:

1. Do you have a heart condition? ❒ Yes ❒ No
2. Do you have chest pain when you do physical activity? or ❒ Yes ❒ No
   In the past month when you have not been doing physical activity? ❒ Yes ❒ No
3. Do you lose of balance due to dizziness or ever lose consciousness? ❒ Yes ❒ No
4. Do you have a history of breathing or lung problems? ❒ Yes ❒ No
5. Do you have muscle, joint or back disorders that could be made worse by a change in your physical activity? (In addition to your joint replacement) ❒ Yes ❒ No

A YES answer to two or more of the following questions requires medical clearance before proceeding with JR2:

1. Do you have diabetes? ❒ Type I ❒ Type II ❒ Borderline ❒ Yes ❒ No
2. Do you have high cholesterol? ❒ Yes ❒ No
3. Are you a current smoker? ❒ Yes ❒ No
4. Do you have high blood pressure (hypertension)? ❒ Yes ❒ No
5. Do you have a sedentary (inactive) lifestyle? ❒ Yes ❒ No
6. Do you have arthritis? Describe type and location: ______________ ❒ Yes ❒ No

Are you currently on any medications or drugs? ❒ Yes ❒ No

If so, please list: ______________________

Have you had surgery other than joint replacement in the last 12 months? ❒ Yes ❒ No

Please describe: ______________________

Do you have any other medical conditions that could affect your ability to exercise? ❒ Yes ❒ No

Please describe: ______________________

All Participants must complete the Participant Informed Consent Form.

Participant Informed Consent Form

I understand that Joint Replacement Recovery or Joint Replacement Pre-Op classes will provide me with a physical activity program. The activities included in my exercise program will be designed to place a gradually increasing workload on the muscular system. 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 any physical activity, including the risks resulting from my participating in the Joint Replacement Physical Activity 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 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 __________________________ , 20 _____

By: ____ ____

Participant's signature Print name

If you answered YES to the health history questions as explained above, you must have the physicians consent form (below) complete prior to commencing the Joint Replacement Exercises Program.

Physician Referral Form and Physical Activity Readiness Conveyance

Your patient is interested in registering for the Joint Replacement Recovery or Joint Replacement Pre-Op Program. The participant will learn the importance of physical activity and will work towards improving his or her strength and balance. As part of the registration process, your client has answered, "yes" to some Health History questions that require medical clearance prior to participation. Joint Replacement Recovery and Joint Replacement Pre-Op are specialized fitness programs that are not medically supervised.

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

Based upon a current review of the health status of ________________________________, I recommend:

Avoidance of: ____

Unrestricted physical activity – start slowly and build up gradually: ________________________________

Additional Comments: ____

____

Blood Pressure: _________ **Date:** _________________ **A1C:** _________ **Date:** ________________

Physician's Signature: ____ **Date:** ________________