Dear Doctor:

Your patient ___________________________ has expressed interest in participating in the Cycle for Parkinson’s sponsored by the UHealth Fitness and Wellness Center. Research has shown that cycling on stationary bikes may benefit people with Parkinson's disease, especially if they cycle hard and fast.

The program consists of a one hour cycling class 2 days per weeks. The program is directed by exercise physiologists degreed in Exercise Physiology and certified through the American College of Sports Medicine as well as certified cycling instructors.

Due to potential risk factors of your patient, we require your permission to allow him/her to participate in the program. If you would allow this patient to participate in our program, please fill out the form on the next page. If you have any additional questions, please contact our staff at (305) 243-7802 or uhealthfitness@miami.edu

Sincerely,

UHealth Fitness and Wellness Center Clinical Exercise staff

Tony Musto, PhD, ACSM-CES
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Cycle for Parkinson’s Referral

Please check which exercise program is appropriate for your patient:

☐ Cycle for Parkinson’s

I am referring and clearing my patient to participate in a Cycle for Parkinson’s program.

Physician’s Signature: ___________________________________ Date: ______________________

If there are any precautions/special conditions please list below.

________________________________________________________________________________________

________________________________________________________________________________________

Patient Information

Name: _________________________________
Phone: ________________________________
Date of Birth: _________________________

Provider Information

Provider Name: __________________________
Phone: _________________________________
Fax: ___________________________________
Email (if preferred): _______________________

Please check any/all that apply:
[ ] Mail me patient updates / progress reports
[ ] Advise me if patient does not pursue program

Fax/email completed form to:

UHealth
FITNESS & WELLNESS CENTER
1120 NW 14 St, 9th Floor
Miami, FL 33136
Tele: (305) 243-7802
Fax: (305) 243-7601
www.wellness.med.miami.edu
UHealthfitness@miami.edu

Note to Patient: Your physician feels you can benefit from participation in this exercise program. This completed form serves as referral and consent to participate in the program. You do not need to get any additional consent.