The Bandeen Center

Physician Approval Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: ____/____/_____

Doctor's Name: _____

Your patient,_____ , DOB_____/_____/____ would like to participate in The Bandeen Center's group programs that are designed for people with Parkinson's disease. Their participation is contingent on: (a) their Parkinson's disease or related diagnosis (see below), and (b) their ability to safely participate in physical activities offered at The Bandeen Center. Please see our website for the most current descriptions.

(a) DIAGNOSIS

Please select the appropriate statements below concerning this patient:

- ☐ The patient has been diagnosed with an accepted diagnosis
- ☐ The patient has not been diagnosed with an accepted diagnosis

Accepted diagnosis include:

- Parkinson's disease
- Corticobasal degeneration
- Dementia with Lewy Bodies
- Multiple system atrophy
- Progressive Supranuclear Palsy
- Vascular parkinsonism

(b) EXERCISE CLEARANCE

Please check one of the following:

- ☐ Patient is cleared for full participation.
- ☐ Patient is cleared with the following restrictions or modifications (please describe):

Physician Signature: _____ Date: ____/____/_____

Scan QR code for electronic copy: