University Hospitals
Avon Health Center

Fitness

1997 Healthway Drive, Avon OH 44011

H.O.P.E. Cancer Exercise Program Referral Form

Submit referral to: Christopher.Ross@UHhospitals.org or Fax: 440-988-6810

Date:_____

Patient Name: _____is interested in the cancer exercise program at the Fitness Center at University Hospitals Avon Health Center.

Please contact this patient at:

Phone number: _____ **Email**:_____

There are specific concerns or conditions staff should be aware of before this individual engages in regular exercise at our facility: Yes No

If yes, please specify:

Restrictions or Recommendations:

Provider name: _____ **Phone:**_____

Provider signature: _____

Address: _____

Email: _____

PARTICIPANT RELEASE AUTHORIZATION

I hereby authorize release of medical information pertinent to restrictions for my exercise program as determined necessary by my healthcare team.

PARTICIPANT SIGNATURE DATE