**The Burke Restorative Neurology Clinic – Robotics**
**785 Mamaroneck Ave Building #1 Room H107 White Plains, NY 10605**

# RISK REVIEW AND PHYSICIAN APPROVAL FORM

The Burke Restorative Neurology Clinic is offering services meant to target community members with neurological impairments. The program is supervised by medical professionals and includes multiple therapy sessions using state of the art robotic devices to expedite a customized exercise program with focus on neurological and motor recovery. The purpose of the program is to provide those with neurological impairments or those who are wheelchair bound, a safe and appropriately supervised place to exercise if a traditional fitness center is not an option.
Please review and sign the following health questionnaire if you feel this program is appropriate for your patient to attend.

**STEP 1. ANSWER FOLLOWING QUESTIONS: STEP 2. HAVE PHYSICIAN SIGN**
IF YOU ARE NOT SURE ABOUT ANY QUESTION, PLEASE ASK YOUR PHYSICIAN.

**NAME: _____ PHONE: _____ Date: _____**

**TABLE 1**

| RISK FACTOR | ACSM RISK FACTOR DEFINING CRITERIA | YES | NO | NOT SURE |
|---|---|---|---|---|
| **1. FAMILY HISTORY** | Has there been a heart attack, coronary bypass, or sudden death before age 55 in father or male first-degree relative (i.e., brother or son), **or**, in mother before age 65 or other female first-degree relative (i.e., sister or daughter)? | | | |
| **2. CIGARETTE SMOKING** | Are you a current cigarette smoker or have you quit within the previous 6 months? | | | |
| **3. HIGH BLOOD PRESSURE** | Has your doctor prescribed medication to control your blood pressure, or, have you had a blood pressure measurement over 140/90 on at least 2 separate occasions? | | | |
| **4. HIGH CHOLESTEROL** | Has your doctor prescribed medication to lower your cholesterol? | | | |
| **5. FASTING GLUCOSE** | Have there been any abnormal fasting glucose measurements on at least 2 separate occasions? | | | |
| **6. OBESITY** | Is your waistline over 40 inches if you are male or 35 inches if you are female? | | | |
| **7. SEDENTARY LIFESTYLE** | Are you participating in a regular exercise program or do you participate in 30 minutes of aerobic activity most days of the week? | | | |

**TABLE 2**

| HAVE YOU HAD ANY OF THESE SYMPTOMS RECENTLY? | YES | NO | NOT SURE |
|---|---|---|---|
| Pain, discomfort in the chest, neck jaw, arms or other areas during exertion? | | | |
| Shortness of breath during rest or mild exertion? | | | |
| Dizziness? | | | |
| Rapid extra heart beats that you can feel? | | | |
| Significant pain in lower legs at rest or mild activity (pain level makes you stop)? | | | |
| Ankle swelling? | | | |
| Do you have a known heart murmur? | | | |
| Unusual fatigue or shortness of breath with usual activities? | | | |
| Episode of Autonomic Dysreflexia? | | | |

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**NAME: _____ PHONE: _____ Date: _____**

**PHYSICIAN NAME:_____ PHONE:_____**

**PHYSICIAN SPECIALTY:_____**

**PHYSICIAN APPROVAL AND RECOMMENDATIONS**
***TO BE COMPLETED BY YOUR PHYSICIAN**

POTENTIAL MODERATE RISK:
*MALE OVER AGE 45;
*FEMALE OVER AGE 55;
*2 OR MORE **YES** ANSWERS IN **TABLE 1**.

POTENTIAL HIGH RISK:
*1 OR MORE SYMPTOMS FROM **TABLE 2**;
*KNOWN CARDIOVASCULAR, PULMONARY OR METABOLIC DISEASE.

**PHYSICIAN CLEARANCE AND RECOMMENDATIONS**

***I approve of my patient's participation in the Burke Restorative Neurology Clinic program, with the following guidelines/recommendations.***

_____
_____
_____

***Physician Name:_____***

***Physician Signature: _____ Phone_____***

**EXERCISE RESTRICTIONS (Optional).**

**□ PLEASE RESTRICT MY PATIENT FROM VIGOROUS EXERCISE.**

**□ Exercise heart rate range: _____ - _____ BPM; and/or, not to exceed: _____BPM**

***How did you hear about us? _____***

***Thank you for helping us guide and encourage your patient to stay active!***
***The Burke Restorative Neurology Clinic – Robotics - Phone: 914-597-2111, Fax: 914-597-2796***