Dear Doctor,

Your patient has applied to attend our Can Do Multiple Sclerosis CAN DO® Program, an education program for people with MS and their support partners. During the four-day program, they have the opportunity to participate in lectures, group discussions, experiential workshops on a variety of wellness topics, as well as sub-maximal fitness assessments, fitball workshops, yoga sessions, and/or aquatherapy. All sessions are facilitated and supervised by trained fitness and physical therapy consultants. These sessions do not serve as clinical assessments/treatments, personal training, rehabilitation, or exercise programs; nor are they intended to screen for possible cardiovascular pathology or other conditions.

The goal of the fitness assessment is to determine the participant's rate of perceived exertion (RPE) on standard exercise equipment (exercise bike, treadmill, arm ergometer etc.). Based on the participant's RPE, abilities, and goals, our consultants work with them to develop individualized exercise recommendations. We encourage participants to discuss these recommendations with their healthcare team prior to implementing.

As part of the program application, we require a Physician Consent Form to ensure safe participation. Please complete the attached Form and note any restrictions, suggested adaptations, and other relevant information. You can fax or email a copy of the signed Form to my attention. Please note that this Form is a mandatory component of the application and must be received within three weeks of your patient's acceptance. Late submissions may affect your patient's application status.

If you have any questions about the attached Form, or about Can Do MS and the CAN DO Program, please do not hesitate to contact me.

Thank you very much for your time.

Regards,

Cari Fehler
Programs Associate
cfehler@cando-ms.org
800-367-3101 ext 1284
970-926-1284
970-926-1295 Fax

**See next page for Physician Consent Form.**

**Time Sensitive Document! Please email to cfehler@cando-ms.org or fax to 970-926-1295.**

# PHYSICIAN CONSENT FOR PARTICIPATION

*Please use this form to provide your recommendations for your patient's participation in sub-maximal fitness assessments as described in the accompanying letter.*

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**Applicant Name:** _____

**1. Physician Information:**

Name _____

Relationship to Applicant (PCP, Neurologist, etc.) _____

Address _____

City _____ State _____ Zip _____

Phone _____

**2. Are there any contraindicating factors, including medications, which would affect the applicant's ability to participate in supervised sub-maximal fitness assessments, fitball workshop, yoga sessions and/or aquatherapy?** Circle one: Yes No

**If yes, please list and explain:** _____

_____

_____

_____

**3. Please identify any recommendations, adaptations, restrictions, or other comments related to the Applicant's participation at the CAN DO program:** _____

_____

_____

_____

**4. Release:** *(check one)*

☐ I approve of Applicant **participating without any restrictions.**

☐ I approve of Applicant **participating with restrictions/adaptations** as described above.

☐ Applicant should **NOT participate** due to his/her current medical status (*please provide explanation).*

Physician's Signature _____ Date _____

**Time Sensitive Document! Please email or fax to Cari Fehler: cfehler@cando-ms.org or 970-926-1295**

PO Box 5860, Avon, CO 81620

**P**: 800.367.3101 **W**: CanDo-MS.org **E**: info@CanDo-MS.org