City of Portland
Parks, Recreation and Facilities Management
Therapeutic Recreation Services
212 Canco Road, Ste A, Portland, Maine 04103
Main Office: 207-808-5400
Rose Cronin: 207-808-5437
Email: rc@portlandmaine.gov

Physician's Recommendation Form

The following information is to be completed by the patient or parent/guardian.

I hereby authorize the release of patient's ***Medical and Other Pertinent Report*** for the use of the City of Portland, Maine Center for Therapeutic Recreation. I understand that the patient's medical history will be held in strict confidence and use is only for professional purposes.

Patient Information

Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Cell Phone:_____

Please Print

Patient/Parent/Guardian Name:_____

Signature:_____ **Date:**_____

Medical Information

We ask that the following information be completed by the individual's physician, psychiatrist or nurse practitioner.

Height:_____ Weight:_____ Blood Pressure:_____

Medical Diagnosis:_____

LIMITATIONS

(Please describe in detail)

Sensory:

Cognitive:

Physical:

Emotional:

Head Trauma:

Multiple:

Other:

Please list any prescribed assistive devices:

Does the individual have an ostomy appliance or stoma? Yes_____ No_____

Is the individual subject to seizures? Yes_____ No_____
If yes, please list the type of seizure they experience_____

Does the individual experience an aura prior to the onset of a seizure? Yes_____ No_____
If yes, please describe the aura or behavior_____

Medications:

_____ _____ _____

_____ _____ _____

Will any of these medications interfere with physical activity: Yes_____ No_____
If so, how:_____
_____

Please list any allergies: Food, medications, latex, other:_____
_____

Medications for allergies:_____

Are all immunizations up to date? Yes_____ No_____

Class Participation

Please indicate any specific precautions and/or recommendations for aquatic and/or physical activity participation.

May individual participate in the following activities?

Please complete the following section by checking the appropriate box

Diving	Yes		No		N/A	
May they dive from the side of the pool	Yes		No		N/A	
Swimming	Yes		No		N/A	
May participant blow bubbles	Yes		No		N/A	
May they put their face in the water	Yes		No		N/A	
Should ear molds or ear plugs be worn	Yes		No		N/A	
Should goggles be worn	Yes		No		N/A	
Should swim mask be worn	Yes		No		N/A	
May swim fins be used	Yes		No		N/A	
May snorkel be used	Yes		No		N/A	
May they go horseback riding	Yes		No		N/A	
May they participate in gym activities of a contact nature	Yes		No		N/A	
Modified tumbling	Yes		No		N/A	
Should he/she be restricted in activities due to Atlantoaxial Dislocation	Yes		No		N/A	
Is this individual required to have an x-ray every two years	Yes		No		N/A	

Physicians Recommendation

I ***DO*** recommend this patient participate in recreation programs sponsored by the Center for Therapeutic Recreation, as noted.

Signature:_____Date:_____

I ***DO NOT*** recommend this patient participate in recreation programs sponsored by the Center for Therapeutic Recreation, as noted.

Signature:_____Date:_____

I would like to receive progress notes on this patient. Yes_____ No_____

Please Print or Stamp Physician's Information

Physician's Name:

Mailing address:

Office Number: Fax Number:

E-mail address: