Retreat Applicant Medical Release

Form to be completed by Physician

Dear Physician,

Please help us by assessing your patient's eligibility to participate in the **Parkinson Wellness Recovery | PWR! Retreat** May 26 – June 1, 2024. The signed Medical Release (see reverse) is required to participate in Retreat exercise programs. PWR! will also conduct its own screening interviews.

The PWR! Retreat is a one-week intensive exercise and enrichment program for persons with Parkinson Disease (PD). The Retreat consists of daily exercise programs including low and/or high intensity aerobic and PD-specific functional skill training. PD-specific exercises include the practice of functional movements that have been shown by research to improve gait, balance, agility, strength, and functional capabilities in people with PD. Daily cardiovascular training may include treadmills, pole walking, stationary bicycles, rowing, and more. The program may also offer enrichment activities such as tai chi, yoga, and dance. Depending on a person's tolerance, up to four (4) hours of exercise programming per day will be available.

PWR! Retreat exercise programs are informed by research and based on the published research of Becky Farley, PhD, MS, PT, the Chief Scientific Officer of Parkinson Wellness Recovery.

Retreat programs are not medically supervised. The class instructors are trained PD-exercise specialists, who in their professional lives are physical, occupational, and speech therapists, and exercise professionals.

If you have any questions, please contact us at (520) 591-5346 or info@pwr4life.org.

Thank you for your assistance,

Dr. Becky Farley
Chief Scientific Officer
Parkinson Wellness Recovery | PWR!

Parkinson Wellness Recovery
4343 N Oracle Rd. Suite 173
Tucson, AZ 85705

www.pwr4life.org
T: 520.591.5346 • F: 888.780.0154

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Applicant Name _____ **Date of Birth** _____

Please print full name

I. Please indicate by an "X" where your patient's current capabilities fall on a continuum.

a. Cognitive Impairment

None	Mild	Mod	Severe

b. Fall Risk

None	Mild	Mod	Severe

c. Limitations on Physical Activity and Endurance

None	Mild	Mod	Severe

II. Restrictions & Recommendations: Please specify any other autonomic issues or co-morbidities that may affect your patient's exercise tolerance, safety, or ability to follow instructions and work in small group exercise classes.

_____

_____

_____

III. My patient may participate in the PWR! Retreat program. Yes _____ No _____

Physician Name (print)_____

Phone Number: _____ Fax Number: _____

Physician Signature _____ Date _____

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