volv Survivorship

Survivorship Program Exercise Prescription

Today's Date ____/____/____

Medical Supervisor _____

Assigned Trainer
Reagan Friend, M.S. of Cancer Care '22
480-268-5497
reaganf.volv@gmail.com

340 E 12th St.
Dubuque, IA 52001
563-556-6496
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General Information	
Patient Name:	DOB:
Phone:	Email:
Primary Health Care Provider:	

Treatment Summary	
Cancer Type:	Clinical Stage:
Surgeries:	Surgery Date(s) (Year):
☐ Radiation	☐ Lymphnode Removal
☐ Other Therapies	Type(s)

Current Drugs/Prescriptions		
Name	Side Effects	Other Notes

Other Comments/Notes:

Risk Assessment

Fill out the information below regarding the medical status of patient at the time of entry to the program. This risk assessment will be used for Reagan to begin her physical assessment.

Date:_____

1. Patient currently participates in exercise? Yes ☐ No ☐

2. Metabolic, CV or other Disease Present Yes ☐ No ☐

List:_____

- Disease is asymptomatic Yes ☐ No ☐

3. Medical clearance is recommended Yes ☐ No ☐

*Medical clearance necessary for non-participant with symptomatic disease

Trainer use only			
Participation Level:	**1**	**2**	**3**
Exercise Level:	Beginner	Experienced	