



## CLINICAL MEMBERSHIP REFERRAL FORM

MUSC WELLNESS CENTER  
45 COURTENAY DRIVE • CHARLESTON, SC 29425  
PHONE: 843-792-5757 • FAX: 843-792-7933

NAME OF PATIENT \_\_\_\_\_ PHONE: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

\_\_\_\_\_

AGE: \_\_\_\_\_ (MUST BE 18 YEARS OR OLDER)

GENDER:  FEMALE  MALE

REASON FOR REFERRAL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The staffing and layout of the Wellness Center accommodates members who are medically stable to exercise and can safely/independently use the exercise equipment. Personal Trainers and Fitness Assessments are available for members who desire a personalized exercise program or ongoing supervision. Fitness Assessments are highly recommended for persons who are starting a new fitness program, persons with known heart disease, or persons with risk factors for cardiac disease (diabetes, high blood pressure, smoking, men >45 years, women >55 years).

REFERRING HEALTH PROVIDER: \_\_\_\_\_

(Please Print)

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_

PROVIDER'S SIGNATURE: \_\_\_\_\_