OREGON
PAIN ADVISORS

Medical Release Form

Pain Resiliency Program
140 S. Holly St.
Medford, OR 97501
Phone: (541) 774-3855
Fax: (541) 787-4711

DATE: _____

Provider Name: _____

Pt Name: _____ DOB: _____

Your patient wishes to start participation in the Pain Resiliency Program. Part of our treatment includes participation in light physical activities designed to increase range of motion, flexibility, strength and endurance. All activities are low impact and are tailored to the needs of persons suffering from chronic pain.

Are there any medical factors in your patient's history or any medications that are currently being taken which would prevent them from participating in this supervised program?

Please circle Yes No

If yes please list and explain:

_____

_____

_____

_____

Please identify any recommendations or physical restrictions regarding your patient's participation in this program.

_____

_____

_____

My patient, as named above, has my approval to begin an exercise program with the recommendations or restrictions stated herein.

Provider signature:_____Date:_____