**DOCTOR’S APPROVAL FORM**

***Tai Chi For Arthritis Program***

Doctor/Physical Therapist’s Name:……………………………….…………………………………………………………

Address:…………………………………………………………………………….…….…...

............................................................................... Post Code:........................

Telephone: ........................................ Fax: ............................. …

Thank you for providing the following information about your patient who wishes to join the Tai Chi for Arthritis Program. All information is strictly confidential and will only be available to class instructors/leaders. This information is used to provide instructors with accurate information in case of emergency, and for appropriate exercise selection.

Please mark and comment on *any medical conditions which may affect your patient‘s participation* in the *Tai Chi for Arthritis* Program.

Medical Condition/s……………………………………………………………..…………..

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Does this patient require an assessment by a physiotherapist prior to entering the *Tai Chi for Arthritis* program? Yes  No 

Are there any movements or situation which should be avoided? Yes  No 

If Yes, name these:

…………………………….……………………………………………………………………...

……………………………………………………………………………………………………

Is there any other relevant information which might affect treatment in an emergency

situation?

……………………………………………………………………………………………………

I advise that (name)……………………………………………………………… is medically fit to participate in the *Tai Chi for Arthritis* program. I have read the ―Program Guidelines‖ (see previous page.)

Doctor‘s Signature: ………………………… ………………Date: …………………………...

**TAI CHI FOR ARTHRITIS ENROLMENT FORM**

Name: .............................................. ……...Date of Birth: .......................................

Address: .................................................................................... ……………………..

 ................................................ ………………… Post Code:......................................

Email: ………………………………………………………………………………………..

Telephone: (Home) ............................................. (Other): ........................................

Contact person in case of emergency: ................................................. ……………..

Telephone: (Home) .............................................. (Other): .......................................

I have read the Tai Chi for Arthritis Program Guidelines and I understand that there is an inherent risk in any exercise activities and I agree to abide by the rules set out in the Program Guidelines. I have no medical contraindication to participating in this workshop or class. I understand if I believe that I might have any medical contraindication to participating in this workshop or class then it is my responsibility to obtain a clearance from my doctor before commencing.

Signature: ............................................................................. Date: .............................

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| **PROGRAM GUIDELINES**Workshop or classes are open to any suitable person as specified per brochure, provided they are medically fit and can participate without assistance in the class. | Any participant who has any doubt whether they are medically fit to attend the workshop or class, are required to have a medical clearance from their doctor prior to commencing the workshop. |
|  Classes usually last for one hour. Participants are encouraged to have a rest in between and to work within their own comfort zone at all times. | Designed by Tai Chi and medical experts led by Dr. Paul Lam and supported by the Arthritis Foundation of Australia. |
| Participants are required to do a gentle warm-up exercise before they start and cooling down exercise afterward. | Trained instructors of this program conduct classes. All certified instructors will be listed online at www.DrPaulLam.com |
| The Tai Chi exercise in this program would be similar to walking in terms of physical exertion. |

 **FOR TCA COORDINATOR ONLY
Instructor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**