DON KNABE WELLNESS CENTER

RT300 FES-SLSA Program
Physical/Occupational Therapy Waiver

Dear Physical/Occupational Therapist,
Your patient, _____, would like to participate in Rancho Wellness Center RT300 FES Bike Program. In order to participate, the patient requires a doctor's prescription and medical clearance from contraindications and cautions to use of the RT300 FES-SLSA and the patient requires a physical/occupational therapy evaluation to assess the following participation criteria:

1. Hip, knee, ankle, shoulder, elbow, wrist joint range of motion adequate for use of the RT300-SLSA
2. Spasticity, if present, does not prevent user from easily pedaling on the RT300-SLSA
3. Pressure of spinal reflexes, residual sensory function, and residual motor function are identified.
4. Setup for use (e.g. electrode placement, stimulation parameters, wheelchair setup) completed.
5. Physiologic responses with use of RT300-SLSA are safe for continued use.

TO BE COMPLETED BY PARTICIPANT

I, _____, authorize my physical/occupational therapist to release the following requested information to Rancho Los Amigos National Rehabilitation Center and to the Los Amigos Research and Education Institute, Inc. for the purpose of participating in Don Knabe Wellness Center.

_____ _____
Signature of Participant Date Signature of Guardian/Parent if minor

TO BE COMPLETED BY PHYSICAL/OCCUPATIONAL THERAPIST (Initial the appropriate line below)

Patient _____ has a prescription to participate in the Rancho Wellness Center RT300 FES-SLSA Program and has a written medical clearance for the contraindications and cautions to use of this equipment. ___ (PT/OT initials)

- **I evaluated this patient on RT300 and reviewed all the contraindications listed above.** ___ (PT/OT initials)
- Patient has not met participation criteria and is **not cleared** to participate. ___(PT/OT initials)
- Patient **has met participation criteria** for use of the RT300 FES-SLSA in the Don Knabe Wellness Center Program with the following conditions:
  - Patient has **no limitations** to participation. ____(PT/OT initials)
  - Patient has **limitations to participation,** however if patient adheres to these limitations, s/he is cleared to participate. Limitations are as follows:

    _____ ____(PT/OT initials)

RT300 Patient ID: __ __ __ __ __ __ __ (required)

_____ _____
Therapist Name (Please print) **Phone Number**

_____ _____
Therapist Signature **Date**

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