RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

DON KNABE WELLNESS CENTER

RANCHO
Research Institute

Standing Program

MEDICAL WAIVER

Dear Doctor,
Your patient, ________________________________, would like to use a standing frame and participate in the Rancho Wellness Center Standing Program. In order to participate, the patient needs to be evaluated and cleared for the following standing contraindications:

1. Orthostatic Intolerance Syndrome (postural orthostatic hypotension)
2. Impaired Skeletal Structure (osteoporosis, osteogenesis imperfecta, heterotopic ossification, any form of brittle bone disease)
3. Severe Contractures
4. Hip Subluxation or other dislocated joints

*If you approve participation by completing the section below, please also refer the patient to Physical Therapy at Rancho Los Amigos for evaluation and training on safe use of the equipment.

TO BE COMPLETED BY PARTICIPANT

I, ______________________________, authorize my doctor 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 the Don Knabe Wellness Center.

____ ________________________________

Signature of Participant **Date** **Signature of Guardian or Parent in minor**

TO BE COMPLETED BY PHYSICIAN (Initial the appropriate line below):

- Patient has medical limitations and is **not cleared** to participate. _______(MD Initials)
- Patient is **medically cleared** for the contraindications listed above and may use a standing frame and participate in the Don Knabe Wellness Center Standing Program with the following conditions:
  - Patient has **no limitations** to participation. ______ (MD Initials)
  - Patient has **limitations to participation,** however if patient adheres to these limitations, s/he is cleared to participate, Limitations are as follows: ______________ ____ ______ (MD Initials)

____ _________________________

Physician's Name (Please print) **Phone Number**

____ _________________________

Physician's Signature **Date**

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