

## To the Physician, Licensed Nurse Practitioner, or Physician's Assistant:

You are being asked to consult on this applicant because we want them to have a safe and healthy experience. These courses contain elements of significant physical stress requiring more strength and endurance than most individuals ordinarily encounter. Your patient may be involved in activities such as:

- **Backpacking w/50-60 lb. pack, hours at a time, over rough terrain**
- **Immersion in cold water**
- **Portaging 70 lb. canoe, up to several miles, across rough terrain**
- **Running on uneven ground**
- **Rock climbing or a ropes course—extreme heights**
- **High altitude hiking/backpacking**
- **Remote wilderness setting**

We have found that people who are in overall good health with average physical ability can successfully complete the program. However, because the programs often take the participants to remote areas where quick access to medical facilities may be delayed for 8 hours or longer, prevention of serious health hazards becomes paramount. We appreciate your help—your assessment of this patient and our knowledge of the course elements will allow us to make an accurate medical screening decision. Thank you!

## A. VITAL SIGNS/STATISTICS Information must be based upon examination done within one year of course start date.

Patient's Name: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_  
 Height: \_\_\_\_\_ ft. \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs. If BP is over 150/90, please repeat:  
 BMI \_\_\_\_\_ Please indicate if the patient is over or underweight: Second Reading: \_\_\_\_\_ / \_\_\_\_\_  
 Overweight by \_\_\_\_\_ lbs, Underweight by \_\_\_\_\_ lbs.  
 Pulse Irregularities: ☐ Yes ☐ No - If yes, please describe symptoms and indicate clinical significance: \_\_\_\_\_

## B. PHYSICIAN'S EXAM Information must be based upon examination done within one year of course start date. Check box if normal; describe if abnormal.

☐ Eyes/Ears

☐ Nose

☐ Throat/Mouth

☐ Lymph Nodes

☐ Thorax/Lungs

☐ CNS

☐ Thyroid

☐ Heart

☐ Heart Murmur

☐ If Murmur, functional

☐ Abdomen

☐ Hernia

☐ Peripheral Vessels

☐ Neck

☐ Back

☐ Shoulders

☐ Knees

☐ Ankles/Feet

☐ Extremities

☐ Skin

☐ Other

Check if the patient is diagnosed with any of the following conditions. If so, indicate if the condition is controlled/stable.

☐ Allergies - food

☐ Hypertension

☐ Allergies – other

☐ High Cholesterol

☐ Asthma

☐ Diabetes

☐ Seizures

☐ Other

### C. SUMMARY OF ACTIVE MEDICAL PROBLEMS AND/OR RESTRICTIONS ☐ NONE (or list below)

### D. PRE-ACCEPTANCE CARDIOVASCULAR TESTING

This program may include a high ropes course and/or rock climbing, or other similar activities. Because these activities can cause both physical stress and anxiety, cardiovascular response may produce an unusually high pulse rate. If this patient is over 40, has a sedentary lifestyle, is significantly overweight, and/or has any of the following cardiovascular risk factors, we may suggest (and in some cases, require) that further cardiovascular testing be done prior to participation in the program:

- Diagnosed high blood pressure, even if being controlled with medication (150/90 or higher in either case)
- Smoking
- Diabetic requiring medication
- Known abnormally high cholesterol level, or on a diet or medication for lipid abnormality
- Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or unexplained death before age 55
- Current cardiovascular disease
- History of prior heart disease
- Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats, exertional dizziness or fainting spells

Do you think an exercise stress test may help assess this applicant's risk of a serious cardiac event during the stresses described above for this course? ☐ Yes ☐ No

Has this patient had an exercise stress test within the past year? ☐ Yes ☐ No

Please forward a copy of the test summary. ☐ Enclosed ☐ Will FAX to: \_\_\_\_\_

**Participation in this program will depend upon the interpretation of the test.**

### E. PHYSICIAN RECOMMENDED REFERRALS

Do you feel further examination or specialty referral is indicated for this patient prior to participation in an Outward Bound program? ☐ Yes ☐ No Please explain:

Consulting Opinion: ☐ Enclosed ☐ Will FAX to: \_\_\_\_\_

### F. IMMUNIZATION

We recommend that all of our participants have a current tetanus immunization (within 10 years).

### G. KNOWN MEDICATIONS If any please list. ☐ NONE (or list below)

Medication List Below	Taken For Symptom/Condition	Dosage Size/Frequency	Date Started	Current Side Effects (if any)

**H. ADDITIONAL COMMENTS** ☐ NONE (or list below)

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**I. PHYSICIAN'S SIGNATURE**

How long have you known the applicant?

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Physician's Name (print):

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Physician's Signature:

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Date of Exam: \_\_\_\_\_ Must be within 1 year of start date.

Telephone: \_\_\_\_\_ FAX : \_\_\_\_\_

Email: \_\_\_\_\_