RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

DON KNABE WELLNESS CENTER

RANCHO
Research Institute

RT300 FES-SLSA Program
Medical Waiver

Dear Doctor,
Your patient, ________________________________, would like to participate in Rancho Wellness Center RT300 FES Bike Program. In order to participate, a general physical examination is recommended; the patient needs a prescription; and must be cleared for the following contraindications and cautions:

1. **Absolute Contradictions** include: Patient with cardiac demand pacemakers; presence of unhealed or unstable fractures in the lower/upper extremities; or pregnancy.
2. **Relative Contradictions** include: Denervated muscle in lower/upper extremity muscles being stimulated; severe spasticity; heterotopic ossification causing severe limited range of motion; severe osteoporosis; Dysaestheic Pain Syndrome; open pressure sores or wounds over treatment area; history of knee/hip/ankle/shoulder/elbow/wrist dislocation or subluxation; or implanted pins, screws, or other surgical hardware in last 3 months.
3. **Caution Advised** for patients with: Any implanted medical device; suspected or diagnosed heart problems; suspected or diagnosed epilepsy; history of uncontrolled autonomic dysreflexia; history of lower/upper limb stress fractures; tendency to hemorrhage following trauma or fracture; or following recent surgery.

***If you approve participation by completing the section below, please also refer the patient to Physical/Occupational 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.

________________________________ ______________________________________

Participant Signature Date Signature of Parent/Guardian if a Minor

TO BE COMPLETED BY PHYSICIAN (Initial the appropriate line below):
Patient _____________, with diagnosis of ____________________________________

- **I have evaluated the patient and reviewed all the contraindications listed above.** _______(MD initials)
- Patient has **no limitations** to participation. _______(MD initials)
- Patient has **limitations to participation,** however if patient adheres to these limitations, she/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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