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LOMA LINDA UNIVERSITY MEDICAL CENTER
BRANDSTATER AMBULATORY REHABILITATION CENTER
ROBOTIC THERAPY WORKSHOP RISK REVIEW

The Brandstater Ambulatory Rehabilitation Center is offering Robotic Therapy Workshops meant to target community members with neurological impairments. The program is supervised by medical professionals and includes multiple therapy sessions, using state-of-the-art robotic devices to expedite a customized exercise program with focus on neurological and motor recovery. The purpose of the program is to provide those with neurological impairments a safe and appropriately supervised place to exercise, if a traditional fitness center is not an option.

Please review and complete the following health questionnaire, if you would like to determine whether this program is appropriate for you to attend.

STEP 1. ANSWER THE FOLLOWING QUESTIONS
STEP 2. HAVE THE PHYSICIAN SIGN THE PHYSICIAN APPROVAL FORM

If you are not sure about any question, please ask your physician.

Name:_____ Phone:_____ Date:_____

Table 1

RISK FACTOR	RISK FACTOR DEFINING CRITERIA	YES	NO	NOT SURE
1. FAMILY HISTORY	Has there been a heart attack, coronary bypass, or sudden death before age 55 in father or other male first-degree relative (i.e., brother or son), or in mother before age 65 or other female first-degree relative (i.e., sister or daughter)?	◯	◯	◯
2. CIGARETTE SMOKING	Are you a current cigarette smoker or have you quit within the previous 6 months?	◯	◯	◯
3. HIGH BLOOD PRESSURE	Has your doctor prescribed medication to control your blood pressure, or have you had a blood pressure measurement over 140/90 on at least 2 separate occasions?	◯	◯	◯
4. HIGH CHOLESTEROL	Has your doctor prescribed medication to lower your cholesterol?	◯	◯	◯
5. FASTING GLUCOSE	Have there been any abnormal fasting glucose measurements on at least 2 separate occasions?	◯	◯	◯
6. OBESITY	Is your waistline over 40 inches if you are male or 35 inches if you are female?	◯	◯	◯
7. SEDENTARY LIFESTYLE	Are you participating in a regular exercise program or do you participate in 30 minutes of aerobic activity most days of the week?	◯	◯	◯

Table 2

HAVE YOU HAD ANY OF THESE SYMPTOMS RECENTLY?	YES	NO	NOT SURE
Pain, discomfort in the chest, neck, jaw, arms, or other areas during exertion?	◯	◯	◯
Shortness of breath during rest or mild exertion?	◯	◯	◯
Dizziness?	◯	◯	◯
Rapid, extra heart beats that you can feel?	◯	◯	◯
Significant pain in lower legs at rest or mild activity (pain level makes you stop)?	◯	◯	◯
Ankle swelling?	◯	◯	◯
Do you have a known heart murmur?	◯	◯	◯
Unusual fatigue or shortness of breath with usual activities?	◯	◯	◯
Episode of Autonomic Dysreflexia?	◯	◯	◯

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Exercise Readiness Questionnaire	YES	NO
Are you over age 65 and not accustomed to vigorous exercise?	◯	◯
Do you have frequent pains in your heart and chest?	◯	◯
Has your doctor ever told you your blood pressure was too high?	◯	◯
Has your doctor ever said you have a bone or joint problem such as arthritis that has been aggravated by exercise?	◯	◯
Has your doctor ever said you have heart trouble?	◯	◯
Is there a good physical reason why you should not exercise even if you wanted to?	◯	◯

Please list any medications and dietary supplements you are taking:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Have you ever had, or do you now have, any of the following conditions?

	Date		Date
• High Blood Pressure	_____	• Osteoporosis	_____
• Stroke	_____	• Arthritis	_____
• Congestive Heart Failure	_____	• Diabetes	_____
• Heart Attack	_____	• Cancer	_____
• High Cholesterol	_____	• Positive TB Test	_____
• Aortic Stenosis	_____	• Peripheral Vascular Disease	_____
• Cardiovascular Surgery	_____	• Recent (1 year) Fracture	_____
• Aneurysm	_____	• Pulmonary Hypertension	_____
• Cardiac Arrhythmia	_____	• Emphysema	_____
• Recent Surgery	_____	• Oxygen Therapy Liters/min _____	_____
• Parkinson's Disease	_____	• Do You Smoke?	_____
• Autonomic Dysreflexia	_____	• Other	_____
• Seizure	_____		

Have there been any complications or limitations from any of the above conditions or events which may be aggravated by exercise? If yes, please explain briefly: _____

_____

Do you have any metal in your head such as shrapnel, surgical clips, or fragments from welding? ☐ Yes ☐ No

Do you have any implanted medical devices such as a pacemaker or medical pump? ☐ Yes ☐ No

Please elaborate on any YES answers and indicate below if there are any other medical conditions not listed on this form.

_____

_____

ROBOTIC THERAPY WORKSHOP PHYSICIAN APPROVAL FORM
Lower Limb Robotics Program

Name:_____ Phone:_____ Date:_____

Physician Name:_____ Phone:_____

Physician Specialty:_____

Diagnosis:_____

Frequency and Duration: 1x/wk x 1 week for a screening; 1-2x/wk for up to 18 visits.
**Workshop is not covered by insurance

Physician Approval and Recommendations
***To Be Completed by Your Physician**

Potential Moderate Risk:
- **Male over age 45**
- **Female over age 55**
- **2 or more YES answers in Table 1**

Potential High Risk:
- **1 or more symptoms from Table 2**
- **Known cardiovascular pulmonary or metabolic disease**

Physician Clearance and Recommendations

I approve of my patient's participation in the Robotic Therapy Workshop, with the following guidelines/recommendations.

_____

_____

_____

*Physician Name:*_____

*Physician Signature:*_____ *Phone:*_____

Exercise Restrictions (Optional)

☐ Please Restrict My Patient From Vigorous Exercise

☐ Exercise heart rate range: _____ - _____ BPM; and/or, not to exceed: _____ BPM

How did you hear about us?_____

Candidates for this program must meet the following requirements:
- Hemiplegia due to a stroke (upper extremity motor function in at least 4/5 in one arm)
- SCI level T4-L5 (upper extremity motor function in at least 4/5 in both arms)
- Involved in a standing program
- Weigh 220 pounds or less
- Height 5-feet tall to 6-feet, 4-inches tall
- Standing hip width of 18 inches or less
- Near normal range of motion in hips, knees and ankles
- Ability to learn and follow directions

ROBOTIC THERAPY WORKSHOP PHYSICIAN APPROVAL FORM
Upper Limb Robotics Program

Name:_____ Phone:_____ Date:_____

Physician Name:_____ Phone:_____

Physician Specialty:_____

Diagnosis:_____

Frequency and Duration: 1x/wk x 1 week for a screening; 1-2x/wk for up to 18 visits.
**Workshop is not covered by insurance

Physician Approval and Recommendations
***To Be Completed by Your Physician**

Potential Moderate Risk:
- **Male over age 45**
- **Female over age 55**
- **2 or more YES answers in Table 1**

Potential High Risk:
- **1 or more symptoms from Table 2**
- **Known cardiovascular pulmonary or metabolic disease**

Physician Clearance and Recommendations

I approve of my patient's participation in the Robotic Therapy Workshop, with the following guidelines/recommendations.

_____

_____

_____

*Physician Name:*_____

*Physician Signature:*_____ *Phone:*_____

Exercise Restrictions (Optional)

☐ Please Restrict My Patient From Vigorous Exercise

☐ Exercise heart rate range: _____ - _____ BPM; and/or, not to exceed: _____ BPM

How did you hear about us?_____

Candidates for this program must meet the following requirements:
- Stroke, Incomplete Spinal Cord (SCI), Traumatic Brain Injury, Multiple Sceloris, Parkinson's or Cerebral Palsy
- Cleared by physician prior to PT screening
- Ability to sit up in a chair for 45 minutes
- Near normal range of motion of shoulder, elbow, wrist and hand. Must have at least an active shoulder shrug
- Healthy skin and bones that can tolerate repetitive exercise
- Ability to learn
- Medically healthy to tolerate repetitive exercise

Liability Waiver

I, _____wish to enroll in the Brandstater Ambulatory Rehabilitation Center Robotic Therapy Workshops at Loma Linda University Health. I understand that exercising in this program may involve a variety of physical activities including, but not limited to, stretching, range of motion, and strengthening with motorized robotic devices. I understand that participation in this program is voluntary and is not covered by insurance. For that reason, I am financially responsible for the cost of the therapy program. I hereby affirm that I do not now suffer, nor have I ever suffered, from any medical condition, impairment, or disability that would prevent or limit in any way my participation in this program.

I fully understand and assume risk that I may suffer injury as a result of my participation in the Brandstater Ambulatory Rehabilitation Center. These risks include, but are not limited to, changes in blood pressure or heart rate, dizziness, muscle strain or pulls, soreness, and in rare cases, serious illness such as heart attack. There is some risk of injury to bones, joints, and/or muscles. I am willing to assume such risk. My physician approves of my participation in this program.

In consideration of my participation in the Brandstater Ambulatory Rehabilitation Center Robotic Therapy Workshops, I for myself, my heirs, executors, administrators, representatives and assigns hereby release and discharge the Brandstater Ambulatory Rehabilitation Center, its employees, subsidiaries, affiliates, offices, directors, agents, successors, assigns, and/or representatives, from any and all claims, demands, causes of action, suits, charges, liabilities, and expenses (including attorney's fees) of any nature whatsoever, now or in the future, arising from my participation in the Brandstater Ambulatory Rehabilitation Center program including, but not limited to, liability related to the injuries listed above, however caused, and whether they occur during or after my participation in these programs.

I hereby affirm that I have read and fully understand the above, and that my signing of this waiver is knowing and voluntary.

Signature:_____ Date: _____

Robotic Therapy Workshop Agreement Form

Name of Patient: _____ Date of Birth: _____/_____/_____

Address: _____ Phone: _____

City: _____ State:_____ Zip:_____

Email: _____ Would you like to receive emails? ☐Yes ☐No

Emergency Contact:_____ Phone: _____

Staff Use Only - Enrollment Date: _____/_____/_____

Workshop Fee:

☐ $600.00 per 4 sessions ($150.00 per session)

☐ $2,700.00 for 18 sessions

PATIENT'S RIGHT TO CANCEL AND RECEIVE REFUND: If you wish to cancel this agreement, and receive a refund of the therapy payment, you may cancel by mailing a written notice to the Brandstater Ambulatory Rehabilitation Center. The notice must say that you do not wish to be bound by this agreement and must be received by us 5 business days prior to program start date ("Cancellation Deadline"). Any notice of cancellation received after the cancellation deadline will not qualify for a refund. The notice must be delivered, faxed, or sent by certified mail. If a patient dies before the completion of the program, no lien will be attached to the patient's estate and a prorated share of the unused portion of the therapy payment may be refunded to the estate.

Patient acknowledges the following:

_____ Except as described above, the therapy payment is non-refundable.

_____ Call Cancel Policy. Call Cancel greater than 24 hours. We will arrange up to 2 make-up sessions accordingly within the 2-week time frame of the therapy program in the event of patient inability to attend due to unforeseen circumstances such as illness, medical appointments, inclement weather and/or personal emergencies.

_____ Payment is due one week prior to start of service. First scheduled session begins the workshop.

_____ Workshop is not covered by insurance. It is a self-pay program.

_____ _____

Signature Date