EMR204840

Women and Newborn Health Service

# ANTENATAL EXERCISE MEDICAL CLEARANCE FORM

**Site:** KEMH ☐ OPH ☐
ID verified ☐ Date _____

Med Rec. No: .....
Surname: .....
Forename: .....
Gender: ..... D.O.B. .....

AFFIX LABEL HERE

## No participation in Antenatal Exercise Classes without signed form completed by your Doctor / Midwife

Join us for some fun and fitness from your 14th week of pregnancy. The physiotherapist will guide you with safe exercises to improve your strength, flexibility and muscle tone. Take this completed form to your first fitness class.

### CONTRAINDICATIONS TO EXERCISE IN PREGNANCY

- ☐ Pregnancy complications
- ☐ Heart condition (angina, medication)
- ☐ Uncontrolled blood pressure (high or low)
- ☐ Epilepsy (unstable)
- ☐ Diabetes (poorly controlled)
- ☐ Peripheral Vascular Disease
- ☐ Skin condition (tinea, plantar warts, allergies, broken skin, ulcers)
- ☐ Bowel problems (faecal incontinence, recent diarrhoea)
- ☐ Risk of, or current, premature labour
- ☐ Cervical incompetence
- ☐ History or risk of IUGR
- ☐ Placenta praevia (after 26 weeks)

### PRECAUTIONS TO EXERCISE IN PREGNANCY
### Please ensure Physiotherapist is notified if any boxes below are ticked

- ☐ Hearing difficulties, recurrent ear infections or grommets
- ☐ Visual impairment
- ☐ Acute inflammatory condition (Rheumatoid Arthritis)
- ☐ Bleeding disorders
- ☐ Diabetes (well controlled)
- ☐ Respiratory conditions (shortness of breath, asthma)
- ☐ Epilepsy (well controlled)
- ☐ Urinary (infections, incontinence)

Relevant Obstetric Medical History (please comment):_____

_____

_____

_____

_____

_____ Dr/Midwife Signed: _____

DO NOT WRITE IN BINDING MARGIN

HCHKEFMR285T

KE719
10/23

MR085.19 (KEMH) / MR62.2 (OPH) PREGNANCY ANTENATAL EXERCISE MEDICAL CLEARANCE FORM

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## DOCTOR / MIDWIFE TO COMPLETE THIS SECTION

Patient Name:_____

Expected Delivery Date:_____ Parity:_____ Blood Pressure:_____

☐ I have completed the contraindications checklist (see overleaf) and consent to my patient attending this class.

Doctor / Midwife Name:_____

Doctor / Midwife Signature:_____

## PATIENT TO COMPLETE THIS SECTION

☐ I understand that if I develop any of the contraindications listed overleaf during my pregnancy, I will inform my medical / midwifery team and physiotherapist.

Patient Signature:_____

Date:_____

DO NOT WRITE IN BINDING MARGIN