Challenge Center 5540 Lake Park Way La Mesa, CA 91942 Phone: (619)667-8644 Fax: (619)667-8647

Challenge Center

Physician Release Form - FES Program

Physician's Name _____ **Date** _____

Patient's Name _____ **Diagnosis** _____

Your patient has elected to participate in the **Computerized Functional Electrical Stimulation Program** (CFES) being offered here at the **Challenge Center.** CFES is electrically stimulated exercise using computerized bicycle ergometry and surface electrodes to initiate muscular contractions in paralyzed extremities of individuals with SCI and other upper motor neuron neuromuscular conditions.

CFES has the potential to

- Enhance cardiovascular fitness
- Enhance circulation, prevent DVT
- Maintain bone density
- Maintain muscle contractile capability
- Increase muscle mass
- Increase or maintain ROM
- Decrease muscle spasms
- Decrease spasticity

CFES, therefore, has the potential to prevent secondary comorbidities associated with SCI and other upper motor neuron neuromuscular conditions, and thus improve quality of life.

"Absolute Contraindications" to FES include

- Implanted pacemaker
- Denervated lower extremity muscles
- Acute fractures
- DVT

Pre-Treatment Screening Tests must include **(to be ordered by physician)**

1. General Physical Examination
2. X-Rays consisting of AP and lateral views of the
   - ✓ Femur
   - ✓ Tibia/fibula
   - ✓ Hips
   - ✓ Knees
   - ✓ Ankle joints
3. EKG
4. SMAC 20 *(to be ordered at M.D. discretion)*
5. Physical Therapy Evaluation (to be provided at the Challenge Center)

Anticipated Treatment Frequency: 1-3x/wk **Duration**: To be determined by patient response and progress

After reviewing the FES contraindications and the results of the Pre-Treatment Screening Tests outlined above, I have determined that:

[ ] Client/Patient is appropriate and can participate without restrictions as tolerated

[ ] Client/Patient is appropriate and can participate with the following limitations: _____

_____

[ ] FES is absolutely contraindicated

[ ] Client/Patient can participate in a fitness program and/or other skilled PT services only.

[ ] I will prescribe the necessary pre-treatment screening tests and forward the results to you.

Physician Comments: _____

_____

Physician's Signature _____ **Date** _____

Please fax this form back to Challenge Center at (619) 667-8647