Date_____

Dear _____,

Welcome to the LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program. We are happy you are joining our program and look forward to getting to know you. The program starts on _____. The program will meet twice a week on _____ and _____. The last day of the program is _____.

We have a few activities planned on the first day, which will help you get acquainted with the YMCA's facility and other program participants. We will be taking a quick tour of the facility so please wear comfortable shoes. You don't need to bring anything with you, but if you'd like you may bring a family member, caregiver or friend.
On the first day we'll become acquainted, tour the facility and explain more about the program. You will also fill out all of the necessary forms and receive LIVE**STRONG** resources you will find valuable.

The YMCA parking lot entrance is on _____ at the _____ end of the building. We will have one of our staff members waiting for you at the entrance to welcome you. You will be provided with an access card which will enable you to enter the YMCA.

Our first session will start in the _____ room.

Directions to the YMCA are available on our website:

www.montclairymca.org

LIVE**STRONG** at the YMCA program is a structured exercise program in a supportive environment. It is designed to improve your cardiovascular fitness, strength, balance and flexibility. Regular attendance and participation creates the group experience and supportive environment, which you'll discover is a valuable part of the program.

We understand you may have appointments or commitments that cannot be changed, just keep us informed if you plan on missing one of the sessions.

If you have any other questions about the program please contact me at _____.

I look forward to seeing you on _____!

Sincerely,

NAME
TITLE
PHONE NUMBER
EMAIL ADDRESS

INFORMED CONSENT

First Name: _____ Last Name: _____

Today's Date: _____Age: _____ Date of Birth: _____ Male or Female

Informed Consent

I understand that the purpose of an exercise program is to develop and maintain cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance. A specific exercise plan will be designed for me, based on my needs and interest. All exercise programs include warm-up, exercise, and cool-down. The programs include, but are not limited to aerobic exercise, strength training, and flexibility. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by the rate of my perceived effort of exercise. I understand that I am responsible for monitoring my own condition throughout the exercise program and should any symptoms occur, I would cease my participation and inform the instructor of the symptoms.

In signing this consent form, I affirm that I have read this form in its entirety and I understand the nature of the exercise program. I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

In the event that medical clearance must be obtained prior to my participation in the exercise program, I agree to consult my physician and obtain written permission from my physician prior to the commencement of any exercise program.

Also, in consideration for being allowed to participate in this exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless the _____, it's employees and agents, from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result in my injury or death, accidental or otherwise, during or arising in any way from the exercise program.

*As part of your participation in **The LIVESTRONG at the YMCA of Montclair**, a program for cancer survivors, we ask that you complete the requested paperwork, surveys, and functional assessments. **All responses/outcomes are kept confidential; your responses/performance will not be shared with anyone outside the LIVESTRONG** program**.** The information you provide may be combined with other respondents answers and analyzed and reported in order to help evaluate the program effectiveness, as well as plan future programs. Thank you for your participation in the program and also for completing the surveys.*

_____ _____

Signature of participant Date

_____ _____

Contact in case of emergency Phone number

Association: Branch:

LIVESTRONG® AT THE YMCA INTAKE FORM

PARTICIPANT INFORMATION

Name:		Date (DD/MM/YY): / /
Preferred phone number:	Email:	Preferred contact method: ☐ Phone ☐ Email
Where were you treated?		
Physician name:		

1. **Date of birth** (DD/MM/YY): ____/____/____
2. **Gender:** ☐ Male ☐ Female
3. **Are you Hispanic, Latino/a, or Spanish origin?** [One or more categories may be selected]

   ☐ No, not of Hispanic, Latino/a, or Spanish origin
   ☐ Yes, Mexican, Mexican American, Chicano/a
   ☐ Yes, Puerto Rican
   ☐ Yes, Cuban
   ☐ Yes, Another Hispanic, Latino/a or Spanish origin
4. **What is your race?** [One or more categories may be selected]

   ☐ White
   ☐ Black or African American
   ☐ American Indian or Alaska Native
   ☐ Asian Indian
   ☐ Chinese
   ☐ Filipino
   ☐ Japanese
   ☐ Korean
   ☐ Vietnamese
   ☐ Other Asian
   ☐ Native Hawaiian
   ☐ Guamanian or Chamorro
   ☐ Samoan
   ☐ Other Pacific Islander
5. **How did you learn about the LIVESTRONG® at the YMCA cancer survivorship program?**

   ☐ Y staff member or volunteer
   ☐ A friend or family member or word of mouth
   ☐ A doctor or other health care professional
   ☐ A local or national cancer awareness or support organization or event
   ☐ A mailing or email communication
   ☐ A poster, or flyer or event at the Y
   ☐ A poster or flyer at a cancer or medical center
   ☐ The Y's website
   ☐ LIVESTRONG
   ☐ Media (TV, web, radio, print, etc.)
   ☐ Other (please specify): _____

HEALTH INFORMATION

6. Have you ever had any of the following health problems?

- Pulmonary (lung) problems ☐ Yes ☐ No
- Heart problems or surgery ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Altered heart rate ☐ Yes ☐ No
- Dizziness or fainting (unrelated to cancer treatment) ☐ Yes ☐ No
- Chest, neck or arm pain ☐ Yes ☐ No
- Pain or cramping in legs while walking ☐ Yes ☐ No
- Short-term weakness on one side of the body ☐ Yes ☐ No
- Elevated blood pressure ☐ Yes ☐ No
- Low blood pressure ☐ Yes ☐ No
- High cholesterol ☐ Yes ☐ No
- Smoker or previous smoker ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Other (please specify): _____

6.a If you answered "YES" to any of the above, please describe briefly (255 character limit):

7. Type of Cancer:

☐ Bladder
☐ Bone
☐ Brain
☐ Breast
☐ Cervical
☐ Colon and Rectal
☐ Endometrial
☐ Esophageal
☐ Head and Neck
☐ Kidney (Renal Cell)
☐ Leukemia
☐ Liver
☐ Lung
☐ Lymphoma
☐ Myeloma
☐ Oral
☐ Ovarian
☐ Pancreatic
☐ Prostate
☐ Rectal
☐ Melanoma
☐ Skin (Non Melanoma)
☐ Stomach (Gastric)
☐ Testicular
☐ Thyroid
☐ Uterine
☐ Other (please specify):

8. Cancer diagnosis date (MM/YY): ____/____

9. Surgery? ☐ Yes ☐ No 9.a. If yes, date of most recent surgery (MM/YY): ____/____

10. Chemotherapy? ☐ Yes ☐ No 10.a. If yes, date of last treatment (MM/YY): ____/____

11. Radiation? ☐ Yes ☐ No 11.a. If yes, date of last treatment (MM/YY): ____/____

12. Do you have an implanted port or Central Venous Access Catheter? ☐ Yes ☐ No

If yes, specify location (50 character limit):

13. Are you experiencing peripheral neuropathy (i.e. tingling/loss of sensation in your fingers and/or toes)? ☐ Yes ☐ No

If yes, specify location (50 character limit):

14. Has the cancer spread to any bones? ☐ Yes ☐ No

If yes, please describe where (50 character limit):

HEALTH INFORMATION CONTINUED…

15. Have you had any lymph nodes removed? ☐ Yes ☐ No

If YES:

15.a. Where have you had lymph node involvement?

☐ Head and Neck
☐ Left Upper Extremity
☐ Left Lower Extremity
☐ Right Upper Extremity
☐ Right Lower Extremity

15.b. Check all that are true:

☐ I have been DIAGNOSED with Lymphedema.
☐ I am currently experiencing STIFFNESS or LOSS OF RANGE OF MOTION in the area that the lymph nodes have been removed.
☐ I am currently experiencing PAIN or DISCOMFORT in the area that the lymph nodes have been removed.

16. Are there any other major illnesses, injury or issues (physical or psychological) we should be aware of? ☐ Yes ☐ No

16.a. If yes, please explain (255 character limit):

17. List current medications, including vitamins and over-the-counter (If not applicable, record 0):

18. Describe your health at the present time: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

PHYSICAL ACTIVITY INFORMATION

19. Do you participate in exercise regularly? ☐ Yes ☐ No

If YES:

19.a Please describe the FREQUENCY of your exercise:

☐ Daily
☐ 2-6 times a week
☐ Once a week
☐ Less than once per week
☐ Monthly

19.b Please describe the INTENSITY of your exercise:

☐ Light
☐ Moderate
☐ Vigorous

19.c Please list the TYPES of exercise you participate in regularly (255 character limit):

PHYSICAL ACTIVITY INFORMATION CONTINUED…

20. Do you have any physical limitations that restrict your daily living activities or ability to exercise? ☐ Yes ☐ No

20.a If yes, please explain (255 character limit):

21. Are there any other limitations since your cancer diagnosis? ☐ Yes ☐ No

21.a If yes, please explain (255 character limit):

22. Are you working? ☐ Yes ☐ No

If YES:	If NO:
22.a What is your level of activity at work? ☐ Sedentary ☐ Light ☐ Moderate ☐ Vigorous	**22.b Since when** (MM/YY)? _____/_____

23. Describe your past experience with resistance training and aerobic training (255 character limit):

24. What expectations do you have from this program (255 character limit):

25. Do you have any concerns about starting this exercise program (255 character limit):

Medical Clearance Form

Date: Physicians' Name:

Client's Name: Physician's Phone:

Client's Phone: Physician's Fax:

Client's DOB:

Dear Doctor _____

Your patient _____ has requested to participate in LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program at the YMCA of Montclair. At the start of this program your client will participate in a fitness assessment, including the 6 minute walk test, one repetition max test for upper and lower body, and balance and flexibility test. Following the fitness assessment, your patient will partake in cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance activities. A specific, individualized exercise program will be created for the participant based on the needs, interests and any recommendations you might have. The LIVE**STRONG** at the YMCA program is designed to start easy and become progressively more difficult over a 12 week period. All fitness assessments and exercise activities will be administered by qualified personnel trained in conducting exercise test and exercise programs.

Based on the LIVE**STRONG** at the YMCA intake form, your patient has indicated a diagnosed medical condition, coronary risk factor, and/or health condition that require a physician's clearance prior to participation in the LIVE**STRONG** at the YMCA program.

By completing the form below, you are not assuming any responsibility for our administration of the fitness assessment or exercise program. If you know of any medical or other reasons why participation in the LIVE**STRONG** at the YMCA program would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the LIVE**STRONG** at the YMCA program, please call the program coordinator.

Program Coordinator: Washima Redding Phone (973) 415-6111 Return Fax (973) 744-1917

_____

Physicians Report

My patient, listed above, is:

_____Not cleared to exercise at this time

_____Cleared to exercise with no restrictions

_____Cleared to exercise with the following restrictions and/or recommendations

_____

_____

Physicians Name: _____

Physicians Signature: _____ Date: _____