NORTON WOMEN'S & CHILDREN'S HOSPITAL

Physician Consent Form Prenatal Yoga

For your safety and the safety of your baby, it is required that this physician consent form be completed and returned prior to your participation in the prenatal yoga class. Please have your obstetrician complete and sign this form. Once completed, please bring this form to the first yoga prenatal class.

Patient Name: _____

Date of Birth: _____

Physician Name: _____

Due Date: _____

ABSOLUTE CONTRAINDICATIONS
The following are absolute contraindications for prenatal yoga.

During this pregnancy, or a prior pregnancy, has your patient had or have a history of:

Yes	No	
☐	☐	Premature ruptured membranes?
☐	☐	Premature labor?
☐	☐	Persistent second or third trimester bleeding?
☐	☐	Placenta previa?
☐	☐	Pregnancy induced hypertension, pre-eclampsia or toxemia?
☐	☐	Incompetent cervix?
☐	☐	Evidence of intrauterine growth restriction?
☐	☐	Multiple pregnancy of 3 or more?

Does your patient currently have or a history of:

Yes	No	
☐	☐	Uncontrolled Type I diabetes, hypertension or thyroid disease?
☐	☐	Serious cardiovascular, respiratory or systematic disease*?

*If yes, please specify disease _____

RELATIVE CONTRAINDICATIONS

Does your patient currently have or a history of:

Yes	No	
☐	☐	History of spontaneous abortion or premature labor?
☐	☐	Anemia or iron deficiency?
☐	☐	Malnutrition or eating disorder?
☐	☐	Mild/moderate cardiovascular or respiratory disease?
☐	☐	Twin pregnancy after 28-weeks?
☐	☐	Other significant medical condition?

Please specify: _____

I give permission for my patient to participate in prenatal yoga sponsored by Norton Healthcare

☐ No restrictions ☐ With restrictions Please specify: _____

Other comments _____

Physician Signature (print) _____

Physician Signature _____ Date: _____