Dear Dr.

Your patient ______________________ (name of patient) would like to participate in a research project that includes a symptom limited graded exercise test to fatigue on an electronically braked bicycle (VO\textsubscript{2}max test). The speed and workload (strength needed to pedal) will begin at a level that can be easily accomplished, and will gradually increase depending upon the patient’s abilities. The speed and workload will be increased until her heart rate is within 85% of her age-predicted maximal heart rate, or until she cannot continue the exercise. It is not desired that she exercise at a level that is abnormally uncomfortable; however, she should exercise as long as is reasonably comfortable. Your patient may stop the test at any time. All testing policy and procedures follow the recommendations of the American College of Sports Medicine. The test will be conducted by an exercise physiologist and an on-site physician will be available at the time of the test for consultation.

We would appreciate your medical opinion and recommendations concerning her participation in this exercise. This test is part of the screening session for a study titled “The IMPACT Study: Inflammatory Responses, Mood, Physical Fitness after Cancer Treatment.”

Please indicate the suitability of your patient to participate in the evaluation.

__________ I feel that she may be evaluated, and I know of no reason why she may not complete a graded exercise test to fatigue.

__________ I feel she may be evaluated, but urge caution due to:

________________________________________________________________________________________
________________________________________________________________________________________

__________ I recommend she not participate in the exercise test.

________________________________________________________________________________________

________________________________________________________________________________________

(Physician’s or Physician Representative’s signature) __________________________________________

____________________________________ __________________________

(Please type or print name) Date

Please return to:
OSU Stress and Health Study
Institute for Behavioral Medicine Research
460 Medical Center Drive, Rm. 130A
Columbus, OH 43210-1257
Fax: 614-366-3627