Return this Medical Release Form to First Descents
Email: programs@firstdescents.org
Fax: 866.592.6911 Attn: Programs

2024 MEDICAL PROVIDER RELEASE FORM

First Descents (FD) provides outdoor adventure programs for young adults impacted by cancer and other serious health conditions. During an FD Program, participants will have the opportunity to engage in various outdoor activities. These activities can be strenuous and occur outdoors away from immediate medical care. The purpose of this Medical Provider Release Form is to provide the FD staff with a comprehensive understanding of the medical conditions currently affecting the Applicant named below (the “Applicant").

As the Applicant's primary Physician/Provider, your opinion of the Applicant's medical fitness for participation in the FD Program described below (the "Program") is requested. In addition to your medical release, we have an internal process to review applicants for conditions that may place them at higher risk for participation. There is an inherent risk with participation in outdoor adventure activities, and we recommend an open discussion with your patient regarding participation risks and benefits, in light of their medical condition. You, their Physician/Provider, have the best information about their current medical condition and how it may affect their ability to safely participate. If needed, First Descents is happy to provide further information about our programming activities to assist in this discussion. There are guidelines attached for your information and reference.

Applicant's Full Name: _____

Applicant's Email:_____ **Date of Birth**:_____

Select all that apply to the Applicant.

CARDIOVASCULAR

- ☐ Coronary artery disease
- ☐ Cardiomyopathy
- ☐ Arrhythmia
- ☐ Pacemaker or AICD
- ☐ Syncope

PULMONARY

- ☐ Chronic lung disease (asthma/COPD/fibrosis)
- ☐ Pulmonary hypertension

ENDOCRINOLOGY

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Adrenal insufficiency

GASTROINTESTINAL

- ☐ Frequent (daily) vomiting or diarrhea
- ☐ Liver failure/cirrhosis
- ☐ Current colostomy/ileostomy

IMMUNOLOGY/INFECTIOUS DISEASE

- ☐ Chronic autoimmune disease (Lupus, RA, etc)
- ☐ Chronic steriod use
- ☐ Chronic immunodeficiency (primary or acquired)
- ☐ HIV with low CD4 or not treated
- ☐ Organ transplant

NEUROLOGIC

- ☐ Frequent migraine headaches
- ☐ Traumatic brain injury
- ☐ Stroke
- ☐ Balance/vertigo/disequilibria that affects walking
- ☐ Seizure
- ☐ Any other sudden alteration in consciousness
- ☐ Multiple Sclerosis

HEMATOLOGY/ONCOLOGY

- ☐ Hemophilia or current use of anticoagulants
- ☐ Cancer

RENAL

- ☐ Chronic renal failure
- ☐ Hemodialysis/peritoneal dialysis

EYE/EAR

- ☐ Significant sight or hearing issues

PSYCHIATRIC

- ☐ Substance use disorder
- ☐ Current psychiatric conditions that are likely to affect participation

ENVIRONMENTAL

- ☐ History of altitude sickness
- ☐ Cold sensitivity

ORTHOPEDIC

- ☐ Amputation
- ☐ Limb paralysis

OTHER

- ☐ Other conditions, concerns or issues that may affect participation
- ☐ Required medical devices (insulin pump, heart monitor, feeding tube, mobility aid, etc)

Please explain any conditions selected above:

_____

_____

_____

SEIZURES/SYNCOPE

[ ] **YES** [ ] **NO** Does the Applicant have generalized seizure disorder?
(see Seizure/Syncope/ALOC Policy below)

If the Applicant has a history of seizures, syncope, or any other sudden altered level of consciousness (ALOC), please describe type, triggers, duration and general overview of symptoms:

_____

_____

_____

What is the frequency of the Applicant's seizures, syncope or ALOC?

- ◘ About once a week or greater
- ◘ About once a month
- ◘ About once every 6 months
- ◘ About once per year
- ◘ It has been more than one year or the Applicant has only had one
- ◘ Not applicable, Applicant does not have a history or currently experience a seizure disorder or lapse or loss of consciousness

[ ] **YES** [ ] **NO** Is the Applicant cleared to drive? (If no, please explain)

_____

MULTIPLE SCLEROSIS

Please specify diagnosis: Relapsing Remitting MS (RRMS), Secondary Progressive MS (SPMS), Primary Progressive (PPMS) or Progressive Relapsing MS (PRMS):

_____

Date Symptoms Began:_____

[ ] **YES** [ ] **NO** Is the Applicant ambulatory?

If no, please explain_____

What is the Applicant's Patient-Determined Disease Step (PDDS)?
(see attached scale below)

0 – normal
1 – mild disability
2 – moderate disability
3 – gait disability
4 – early cane
5 - late cane
6 - bilateral support
7 - wheelchair/scooter
8 - bedridden

[ ] **YES** [ ] **NO** To your knowledge, does the Applicant experience any issues with muscle control that would limit their ability to participate in an outdoor adventure program, including but not limited to muscle weakness, cramps, or spasticity?

HEMATOLOGY/ONCOLOGY

[ ] **YES** [ ] **NO** Does the Applicant have a bleeding disorder (e.g. Hemophilia, etc.) or will they be taking blood thinners at the time of participation? (see Anticoagulation Policy below)

Type/Dosage:_____

Please Describe indication for anticoagulant therapy or type of bleeding disorder:

_____

Estimated duration of anticoagulation therapy or target date for stopping therapy:

_____

If there is a history of cancer, please answer the following:

Diagnosis:_____ Primary site of cancer: _____

Date of diagnosis: _____ Date of relapse (if any):_____

[ ] **YES** [ ] **NO** Evidence of disease?

Date Applicant was listed as no evidence of disease:_____

[ ] **YES** [ ] **NO** Treated with Chemotherapy?

Radiation therapy (indicate area of the body)? _____

Surgery (please explain): _____

_____

[ ] **YES** [ ] **NO** Has the Applicant completed treatment?

If no, when was the Applicant's last course of treatment?_____

Type:_____

If currently receiving Chemotherapy, when is treatment anticipated to be completed?

_____

[ ] **YES** [ ] **NO** Any Chemotherapy or radiation in the month prior to their program?

If yes, please specify_____

[ ] **YES** [ ] **NO** If yes, do you expect that the patient might experience Myelosuppression or other chemo-related toxicities during the time of the program?

If yes, please explain_____

[ ] **YES** [ ] **NO** Will your patient be taking medications to prevent Myelosuppression (Granulocyte-Colony Stimulating Factor (GCSF) analogs) at the time of participation?

If yes, please explain_____

[ ] **YES** [ ] **NO** Does the Applicant have significant Splenomegaly?

If yes, please explain_____

PAST SURGICAL HISTORY: Please list history of all past surgeries:

_____

_____

_____

_____

MEDICATIONS:

[ ] **YES** [ ] **NO** Is the Applicant currently prescribed any opioid medications?

If yes, please specify_____

Please list all medications, dosage and schedule required during the program:

MEDICATION	DOSE	SCHEDULE

ALLERGIES:

_____

_____

_____

_____

[ ] **YES** [ ] **NO** Does the physical exam have abnormalities relevant to participation?

Please explain: _____

Does Applicant have any other medical issues or concerns not previously outlined?

_____

_____

PHYSICIAN'S STATEMENT

I attest that all of the medical information listed above including diagnoses, disabilities, and medications are correct and true. Regarding conditions that might increase risk of participation (seizures, syncope, bleeding disorders), the applicant and I have discussed the risks and benefits of participation.

Based on my responses in this Medical Provider Release Form:

_____ I find no medical conditions currently present in the Applicant that I consider incompatible with participation on the Program.

_____ I am unable to recommend the Applicant for participation on the Program.

Should any medical emergency arise during this activity, I have provided telephone numbers where I may be reached for medical consultation concerning the welfare of the Applicant. Please note, the Physician/Provider's contact information displayed is private and will not be shared with anyone except FD staff and medical reviewers, or as otherwise outlined in the Medical Authorization Statement and Consent, included in the Medical Provider Release Form.

Physician/Provider Full Name:_____

Physician/Provider or Hospital Email Address:_____

Emergency Office Phone:_____ **Emergency Home Phone:**_____

Hospital Name_____ **Hospital Phone**_____

Signature_____ **Date of Signature**_____

NOTE: Information displayed or shared here is private and will not be shared with anyone except FD staff and medical reviewers, or as otherwise released by the Applicant. All applicants MUST have this form completed by their physician and returned to FD before being accepted to attend an FD Program. Thank you for completing this information. It will help our staff provide a high-quality experience for the Applicant.

MEDICAL PROVIDER RELEASE POLICIES

There is an inherent risk with participation in outdoor adventure activities, and First Descents (FD) has identified several common conditions that may pose an elevated risk for your patient and have specific relevance to the nature of our program offerings. You, their Physician/Provider, have the best information about the Applicant's current medical condition and how it may affect their ability to safely participate. Please review these below regarding participation risks and benefits and have an open discussion with your patient so they can make an informed decision regarding participation.

If needed, FD is happy to provide further information about our programming activities to assist in this discussion.

Altitude illness: Many of our programs are located at high altitude. This may pose a problem for patients with underlying conditions such as anemia, cardiovascular problems, or a history of altitude illness. We do have programming that is not located at high altitude, and this may be most appropriate for patients who are considered higher risk by their provider.

Anticoagulant use/bleeding disorder: While our programming typically carries a very low risk of injury, this risk is not zero, and this should be discussed with patients who may have bleeding disorders. We take necessary safety precautions, and our staff is aware of the need for evaluation with minor head trauma or signs of bleeding. Please ensure that your patient understands this risk and brings any necessary medication. If the patient is to be on short-term anticoagulants, the safest course may be to delay participation until their therapy is completed.

End-stage disease: FD wants to extend its programming to as many participants as possible, and this includes participants with a high disease burden and those with incurable conditions. However, we are not designed as a program that specifically serves a population suffering a terminal disease in its later stages. Those with rapidly escalating care needs may find themselves unable to meaningfully participate, or may even need to be evacuated for their safety. If there are any questions, please contact First Descents staff to discuss further.

Mental health crisis: Chronic medical conditions are clearly a psychological stressor. When coupled with the stresses of travel away from family and an unfamiliar environment, patients can often have some of their underlying mental health issues exacerbated. While FD does assess an applicant's mental health before and during our programs, we feel it is best to defer participation for those who are currently struggling with more severe mental health issues, such as those at risk for suicide, those who have had a recent psychiatric hospitalization, and those whose psychiatric conditions are not stabilized.

Myelosuppression/immunocompromised: Patients at risk for myelosuppression or who are immunocompromised are at increased risk for acquiring infections when in group situations and in an outdoor environment. If your patient is currently undergoing treatment that risks myelosuppression, FD may require further provider acknowledgement that participation is safe (e.g., additional blood testing to exclude neutropenia, etc.)

Seizure, syncope, altered level of consciousness: FD reviews the symptoms and frequency of the episode(s) to determine an Applicant's likelihood of an occurrence on programs and if the episode(s) affect their ability to individually and safely participate, which includes ability to maintain balance, hold a standing position, maintain their airway, verbally communicate with others, and physically assist in their own self-rescue, if required (e.g., wet exit a hard-shell kayak, swim, paddle, climb, belay/rappel, avoid hazards, and navigate uneven terrain, including in the water). An episode can pose risk to a participant in an outdoor adventure activity, but we do attempt to offer modifications, specific activities and precautions to make this risk as low as possible. This includes but is not limited to restricting some Applicants to land-based programming (given the unique risks of water-based programming), or deferring participation if their condition poses a risk to their ability to individually and safely participate.

Severe allergies: FD makes all attempts to accommodate participants with food allergies, as well as mitigate exposure to environmental allergens. However, please ensure that your patient has the required medication to bring with them to camp (e.g., an EpiPen).

[MS PATIENT-DETERMINED DISEASE STEPS]

0 – normal: mild symptoms, mostly sensory, but does not limit activity

1 – mild disability: some noticeable symptoms, but they are minor and have a small effect on lifestyle

2 – moderate disability: no walking limitations; MS symptoms limit daily activities in other ways

3 – gait disability: activity limitations, especially walking, but usually doesn't need assistance

4 – early cane: use of a cane or a crutch, but can walk 25 feet in 20 seconds without support

5 – late cane: use of a cane or a crutch to walk 25 feet; may use a scooter or wheelchair for greater distances

6 – bilateral support: use of 2 canes, crutches, or a walker to walk 25 feet; may use a scooter or wheelchair for greater distances

7 – wheelchair / scooter: main mode of mobility is via wheelchair

8 – bedridden: unable to sit in a wheelchair for more than one hour