Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Informed consent for Exercise Testing

**Purpose and Explanation of the Test**

To assess your fitness level, you will be asked to complete the multiple assessments from the “Senior Fitness Test (SFT)”. The SFT is a battery of tests developed to assess various fitness components among older adults. Many older adults have performed these combinations of tests and normal reference ranges have been established. The components of SFT are as follows:

*Aerobic Fitness:* To determine your aerobic fitness you will be asked to march in place for two minutes, raising your knees to a height that corresponds to half of the distance between your hip and knee.

*Upper Body Endurance:*  To determine your upper body endurance you will be asked to perform as many arm curls as possible within a 30 second time frame using a hand held weight of either 5 pounds (women) or 8 pounds (men).

*Lower Body Endurance:*  To determine your lower body endurance, you will be asked to stand up and sit down out of a chair, without using your arms, as many times as you are able to in a 30 second time frame.

*Upper Body Flexibility:*  To determine your upper body flexibility, you will be asked to complete the “back scratch test” where you will reach one arm over your head and down toward your back, while reaching up your back with the other hand. Your score will be the number of inches separating your two hands.

*Lower Body Flexibility*: To determine your lower body flexibility, you will be asked to perform a modified sit and reach test. Seated in a chair, you will extend one leg in front of you and, bending at the hip, reach your fingers toward your toes. Your score will be the number of inches separating your fingertips from your toes.

*Functional Mobility:*  To determine your functional mobility you will be perform the “8 foot up and go.” Beginning from a seated position, you will be asked to stand up, walk 8 feet, turn around a cone and return to the chair and sit down. Your score will be the time it takes to complete this task.

In addition to the above tests, your balance will also be determined through various assessments. Examples of these tasks include, standing in a tandem stance (heel of one foot touching the toe of the other foot) or standing on one leg (if you are able). You will also be asked to walk a 10 foot line, in a heel-toe fashion. There may also be other assessments performed as deemed appropriate by Dr. McNamara.

**Attendant Risks and Discomforts**

There exists the possibility of certain changes occurring during the test. These include abnormal blood pressure; fainting; irregular, fast or slow heart rhythm; and, in rare instances, heart attack, stroke or death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by careful observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations that may arise. There are also risks of fatigue and muscular soreness from this test. These symptoms usually resolved within 2-3 days.

**Responsibilities of the Participant**

Information you possess about your health status or previous experiences of heart-related symptoms (e.g. shortness of breath with low-level activity, pain, pressure, tightness, heaviness in the chest, neck, jaw, back and/or arms) with physical effort may affect the safety of your exercise test. Your prompt reporting of these and any other unusual feelings with effort during the exercise test itself is very important. You are responsible for fully disclosing your medical history, as well as symptoms that may occur during the test. You are also expected to report all medications (including non-prescription) taken recently and , in particular, those taken today, to the testing staff.

**Benefits to Be Expected**

The results obtained from the exercise test may assist in the diagnosis of your illness, in evaluating the effect of your medications or in evaluating what type of physical activities you might do with low risk.

**Inquiries**

Any questions about the procedures used in the exercise test or the results of your test are encouraged. If you have any concerns or questions, please ask us for further explanations.

**Use of Medical Records**

The information that is obtained during exercise testing will be treated as privileged and confidential as described in the Health Insurance Portability and Accountability Act of 1996. It is not to be released or revealed to any person except your referring physician without your written consent. However, the information obtained may be used for statistical analysis or scientific purposes with your right to privacy retained.

**Freedom of Consent**

I hereby consent to voluntarily engage in an exercise test to determine my exercise capacity and state of cardiovascular health. My permission to perform this exercise test is given voluntarily. I understand that I am free to stop the test at any point if I so desire.

I have read this form, and I understand the test procedures that I will perform and the attendant risks and discomforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this test.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date

 

**INFORMED CONSENT FOR PARTICIPATION  IN A HEALTH AND FITNESS TRAINING PROGRAM**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. PURPOSE AND EXPLANATION OF PROCEDURE**

I hereby consent to voluntarily engage in an acceptable plan of personal fitness training. I also give consent to be placed in personal fitness training program activities which are recommended to me for improvement of dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test prior to the start of my personal exercise prescription program in order to evaluate and assess my present level of fitness.

I will be given exact personal instructions regarding the amount and kind of exercise I should do. Dr. McNamara, an ACSM certified Health Fitness Specialist, will provide leadership to direct my activities, monitor my performance, and otherwise evaluate my effort. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during exercise testing to regulate my exercise within desired limits. I understand that I am expected to complete the exercise prescription as I am able and to follow staff instructions with regard to exercise, stress management, and other health and fitness regarded programs. If I am taking prescribed medications, I have already so informed Dr. McNamara and further agree to so inform her promptly of any changes which my doctor or I have made with regard to use of these. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of the program.

I have been informed that during my participation in the above described exercise program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar occurrences appear. At this point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform Dr. McNamara of my symptoms, should any develop. I also understand that Dr. McNamara may reduce or stop my exercise program when any findings so indicate that this should be done for my safety and benefit (e.g. changes in pulse, blood pressure, feelings of effort).

I also understand that during the performance of my personal fitness training program physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above.

**2. RISKS**

It is my understanding and I have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by proper staff assessments of my condition before each personal fitness training session, staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as herein indicated.

**3. BENEFITS TO BE EXPECTED AND ALTERNATIVES AVAILABLE TO EXERCISE**

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the exercise prescription will allow me to learn proper ways to perform conditioning exercises, use fitness equipment and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-6 months.

**4. CONFIDENTIALITY AND USE OF INFORMATION**

I have been informed that the information which is obtained in this personal fitness training program will be treated as privileged and confidential and will consequently not be released or revealed to any person, to the use of any information which is not personally identifiable with me for research and statistical purposes so long as same does not identify my person or provide facts which could lead to my identification. Any other

information obtained, however, will be used only by the program staff to evaluate my exercise status or needs.

**5. INQUIRIES AND FREEDOM OF CONSENT**

I have been given an opportunity to ask questions as to the procedures.

**I have read this Informed Consent form, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily, without inducement.**

**Participant’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant’s Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[www.ExerciseIsMedicine.org](http://www.ExerciseIsMedicine.org)  -- www.psneurology.com---253-284-4488

**Puget Sound Neurology and Integrative Health Center**

**HEALTH & MEDICAL QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, whom may we contact?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Cell):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal physician

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present/Past History**

Have you had or do you presently have any of the following? (Check if yes.)

\_\_\_\_\_\_ Rheumatic fever

\_\_\_\_\_\_ Recent operation

 \_\_\_\_\_\_ Edema (swelling of ankles)

\_\_\_\_\_\_ High blood pressure

\_\_\_\_\_\_ Low blood pressure

 \_\_\_\_\_\_ Injury to back or knees

 \_\_\_\_\_\_ Seizures

\_\_\_\_\_\_ Lung disease

 \_\_\_\_\_\_  Heart attack or known heart disease

* \_\_\_\_\_\_  Fainting or dizziness
* \_\_\_\_\_\_  Diabetes
* \_\_\_\_\_\_  High Cholesterol
* \_\_\_\_\_\_  Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) or nocturnal dyspnea (shortness of breath at night)
* \_\_\_\_\_\_  Shortness of breath at rest or with mild exertion
* \_\_\_\_\_\_  Chest pains
* \_\_\_\_\_\_  Palpitations or tachycardia (unusually strong or rapid beat)
* \_\_\_\_\_\_  Intermittent claudication (calf cramping)
* \_\_\_\_\_\_  Pain, discomfort in the chest, neck, jaw, arms, or other areas
* \_\_\_\_\_\_  Known heart murmur
* \_\_\_\_\_\_  Unusual fatigue or shortness of breath with usual activities
* \_\_\_\_\_\_  Temporary loss of visual acuity or speech, or short-term numbness or weakness  in one side, arm, or leg of your body
* \_\_\_\_\_\_\_ Cancer
* \_\_\_\_\_\_\_ Osteoporosis of hip or spine
* \_\_\_\_\_\_  Other (please describe):

**Family History**  Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

* \_\_\_\_\_\_ Heart attack
* \_\_\_\_\_\_ Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)
* \_\_\_\_\_\_ Congenital heart disease
* \_\_\_\_\_\_ High blood pressure
* \_\_\_\_\_\_ High cholesterol
* \_\_\_\_\_\_ Diabetes
* \_\_\_\_\_\_ Other major illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Explain Checked items**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activity History**

1. How were you referred to this program? (Please be specific.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Why are you enrolling in this program? (Please be specific.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever worked with a personal trainer before? Yes \_\_\_\_\_ No \_\_\_\_\_
4. How many hours do you spend sitting each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. How would your rate your occupational activity? Desk job\_\_\_\_light activity\_\_\_ moderate activity\_\_\_\_heavy labor\_\_\_\_\_ retired\_\_\_\_\_\_\_\_
6. Do you ever have uncomfortable shortness of breath during exercise of when doing activities? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_
7. Do you ever have chest discomfort during exercise? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_
	1. If yes, does it go away with rest? Yes\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_
8. Do you currently engage in moderate or vigorous physical activity on a regular basis? Yes\_\_\_\_\_\_no\_\_\_\_\_\_\_\_\_
	* + 1. If so, what types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many days/week? \_\_\_\_\_\_\_\_\_
			2. How much time per day? <15 min \_\_\_\_ 15-30 min\_\_\_\_ 31-60 min\_\_\_\_>60 min\_\_\_\_
			3. How long have you engaged in this type of activity? <3 month 3-12 month 1 year
9. Can you currently walk 3 miles briskly without fatigue?

 Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

1. Have you ever performed resistance training exercises in the past?

Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

1. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes \_\_\_\_\_\_No \_\_\_\_\_\_ If yes, briefly describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you smoke? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ If yes, how much per day and what was your age when you started? Amount per day \_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_
3. What is your body weight now? \_\_\_\_\_\_\_What was it one year ago? \_\_\_\_\_\_\_\_ At age 21? \_\_\_\_\_\_\_
4. How tall are you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. In the previous 6 months, how often have you fallen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the circumstances of the fall. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. On a scale of 1 to 10, with 1 being not at all and 10 being extremely, how worried are you about falling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you follow or have you recently followed any specific dietary intake plan and, in general, how do you feel about your nutritional habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. List the medications you are presently taking (if an established patient of PSN, you can skip this step). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. List in order your personal health and fitness objectives (i.e. what are your goals for this process of starting an exercise program):

a.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 b.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any barriers you perceive to starting and continuing an exercise program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_