NSW GOVERNMENT

Health
Northern Sydney
Local Health District

Facility: COM HKH MQE MV RNS RYD

AQUATIC PHYSIOTHERAPY MEDICAL CLEARANCE

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. / /	M.O.
ADDRESS	
	PH
M/C	FIN
LOCATION / WARD	ADM / /

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Phone Number..... Interpreter: ☐ Yes ☐ No If yes, language.....

Reason for Referral: (Please indicate joint/s involved as applicable)

Weight Bearing Status: (if applicable)

Medical History:

If these conditions are NOT CONTROLLED the patient is NOT SUITABLE to participate in aquatic physiotherapy

- ☐ Hypertension /hypotension
- ☐ Cardiac conditions
- ☐ Pacemaker: ☐ Yes ☐ No
- ☐ Diabetes
- ☐ Epilepsy/seizures Frequency.....
- ☐ Documented evidence of mental health condition

Contraindication

- ☐ Urinary/faecal incontinence
- ☐ Stroke within past 3 weeks
- ☐ Gynaecological infections, UTI, gastroenteritis

Precautions

- ☐ Open wounds, broken skin (e.g. psoriasis, dermatitis)
- ☐ High risk of aspiration/swallowing defects
- ☐ Venous access lines
- ☐ Catheter/colostomy
- ☐ Recent major surgery (i.e. cardiac/ ortho/ neuro)
- ☐ Infective skin conditions (e.g. tinea)
- ☐ Cytotoxic medications
- ☐ Cognitive/psychological/behavioural impairment
- ☐ Respiratory conditions

- ☐ Pregnancy Due Date: / /
- ☐ Infectious diseases Please specify.....
- ☐ Multi resistance organism Please specify.....
- ☐ Renal problems Dialysis..... Frequency.....

Current Medications:

Patient can participate in a group setting without requiring individual attention: ☐ Yes ☐ No

COR5021

Holes punched as per AS2828 - 2012

BINDING MARGIN – NO WRITING

MEDICAL CLEARANCE: AQUATIC PHYSIOTHERAPY

JUL19/V5

CATALOGUE NUMBER NS10196

MARGIN – NO WRITING

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Patient Consent

☐ I consent to participation in aquatic physiotherapy treatment
☐ I have read and understood the pool rules and cancellation policy and agree to abide by them
☐ I am aware that failure to comply with pool rules may result in cancellation of my future appointments
☐ I will inform the Physiotherapy staff if my condition changes during my period of attendance
☐ I consent to my Physiotherapist liaising with my medical practitioner if required during the course of my treatment.

Name .....

Signature .....

Date: / /

Physician/Physiotherapy Certification

This is to certify ..... (name) has been assessed and is suitable for aquatic physiotherapy.

Name ..... Signature .....

Designation ..... Date: / /

BINDING MARGIN - NO WRITING

Holes punched as per AS2828 - 2012