GREENWICH HOSPITAL HYDROTHERAPY REFERRAL / MEDICAL CLEARANCE FORM

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
DOB	M.O
ADDRESS	
LOCATION/ WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Patient name: ______________________ Date of Birth: ______________ Sex: ________

Address: ____

Home phone no: ______________________ Mobile: ______________________

Diagnosis: ____

Relevant Medical History: ____

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Goals: ____

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CHECKLIST FOR PRECAUTIONS AND CONTRAINDICATIONS

CONDITIONS *(Please tick the check box)*	Yes	No	COMMENT
Heart conditions (angina/medication)	☐	☐	
Uncontrolled blood pressure (high or Low)	☐	☐	
Epilepsy (frequency of fitting)	☐	☐	
Respiratory conditions (shortness of breath, asthma)	☐	☐	
Integrity of skin (wounds, ulcers)	☐	☐	
Cancer (undergoing deep radiotherapy, chemotherapy)	☐	☐	
Genito-urinary tract: Infections, incontinence, catheter	☐	☐	
Contagious diseases (hepatitis, AIDS) if yes no pool entry when menstruation occurs	☐	☐	
Current active infections	☐	☐	
Pregnancy	☐	☐	
Dizziness episodes/ fainting/ Vertigo	☐	☐	
Other precautions:	☐	☐	

This person has been assessed and identified as medically suitable for hydrotherapy and has no condition that would prevent attendance at hydrotherapy ☐ Yes ☐ No

Referring GP/Specialist

Name: ______________________

Address: ______________________

____

Provider no: ______________________

Signature: ______________________

Date: ______________________

Please forward completed form and attachments to:

Ambulatory Rehabilitation Service
Greenwich Hospital Ambulatory Service
PO Box 5084, 97-115 River Road
Greenwich NSW 2065
Ph: 0467 505 646 Fax: (02) 99038269
email: greenwichrehab@hammond.com.au

BINDING MARGIN – NO WRITING

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