



**REHABILITATION AMBULATORY SERVICES  
HYDROTHERAPY REFERRAL / MEDICAL  
CLEARANCE FORM**

FAMILY NAME	MRN
GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> 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: \_\_\_\_\_

Goals: \_\_\_\_\_

**CHECKLIST FOR PRECAUTIONS AND CONTRAINDICATIONS**

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

*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:**

Rehabilitation Ambulatory Services  
HammondCare Pacific Centre  
38 Pacific Highway  
St Leonards NSW 2065  
Ph: 0467 505 646 Fax: (02) 99038269  
email: [greenwichrehab@hammond.com.au](mailto:greenwichrehab@hammond.com.au)

BINDING MARGIN – NO WRITING

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