Surname:	Given Name:
Address:	
D.O.B.	GP

HammondCare
An independent Christian charity

PH (H) **(Mob)**

HYDROTHERAPY REFERRAL

Diagnosis: _____

_____

Relevant Medical Hx: _____

_____

Goals: _____

_____

CHECKLIST FOR PRECAUTIONS AND CONTRAINDICATIONS

Yes	No	Comment
☐	☐	Heart condition (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) _____
☐	☐	Bowel problems (incontinence, colostomy) _____
☐	☐	Contagious diseases (hepatitis, aids) _____ (*If yes, then no pool entry when menstruation occurs)*
☐	☐	Current active infections _____
☐	☐	Pregnancy _____
☐	☐	Dizzy Episodes/Fainting/Vertigo _____
☐	☐	Other Precautions _____

Would any of the above prevent hydrotherapy? _____

Doctors Name: _____ Contact Tel No: _____ Fax No: _____

Address: _____ P/Code: _____

Signature: _____ Date: _____

Please send completed form to Greenwich Hospital Hydrotherapy (Phone 9903 8387)
PO Box 5084, Greenwich 2065 or Fax to 9903 8269