

HYDROTHERAPY REFERRAL MEDICAL CHECKLIST

DEAR DR. _____

WHEN YOUR PATIENT ATTENDS OUR POOL CLASSES, HE / SHE IS EXERCISING IN WATER UP TO 34°C.
THIS PLACES SOME PHYSICAL STRESS UPON THE BODY.

IN ORDER FOR YOUR PATIENT TO ATTEND HYDROTHERAPY, THIS FORM **MUST** BE COMPLETED.

NAME: _____ DOB: _____

CONDITION REQUIRING TREATMENT: _____

1. CARDIAC	UNSTABLE ANGINA	YES / NO
2. BLOOD PRESSURE	CURRENT READING	
	DIZZINESS	YES / NO
	UNSTABLE	YES / NO
3. LUNG CAPACITY	SOBOE	YES / NO
4. SKIN CONDITION	TINEA	YES / NO
	INFECTIONS	YES / NO
	OPEN WOUNDS	YES / NO
5. EPILEPSY	ANY FITS IN LAST 12 MONTHS?	YES / NO
6. STROKES	CVA OR TIA IN LAST 3/52	YES / NO
7. DIABETES	IS THE PATIENT DIABETIC	YES / NO
	IS IT STABLE AND WELL CONTROLLED?	YES / NO
8. P.V.D.	DORSALIS PEDIS PULSES PRESENT?	YES / NO
	HISTORY OF ISCHAEMIC ULCERS?	YES / NO
9. INCONTINENCE	URINARY INCONTINENCE	YES / NO
	FAECAL INCONTINENCE	YES / NO
10. PERFORATED EARDRUM	MUST WEAR EAR PLUG AND NOT SUBMERGE HEAD	YES / NO

- We expect the patient to have a reasonable aerobic capacity as they will be exercising moderately and we expect to attain a pulse rate of 100-120 beats per minute.
- We recommend a 3 monthly review of these contraindications.

I BELIEVE THAT THE ABOVE PATIENT IS FIT FOR A COURSE OF SIX WEEKS HYDROTHERAPY, IF DEEMED FOR THE CONDITION. HE / SHE WILL REQUIRE ASSISTANCE WITH (PLEASE CIRCLE IF APPROPRIATE):

DRESSING / SHOWERING / AMBULATION / WHEELCHAIR

SIGNED _____ DATE _____