



# Community Physiotherapy Services

## Referral form

### CPS OFFICE USE ONLY

Database ID: \_\_\_\_\_  
 Not allocated  
 Allocated: Class: \_\_\_\_\_ Day/Time: \_\_\_\_\_

Thank you for referring your client to Community Physiotherapy Services. All our programs are conducted in a group setting in community venues; therefore, all clients must be medically appropriate to exercise in a community setting, cognitively appropriate for a group-based program and able to toilet and dress independently, or with a carer in attendance at the class to assist.

In order to place your client in the most appropriate program, and in the interest of client safety we request the following information.

Client Details	
Name: _____ Date of Birth: _____	
Phone (Day): _____ (Mobile): _____	
Address: _____	
Contact if other than client: Name: _____	
Relationship to client: _____ Phone: _____	
Medical Practitioner details	Referrer Details (if other than Medical Practitioner)
Name: _____	Name: _____
Address: _____	Designation: _____
Phone: _____	Address: _____
Email: _____	Phone: _____
<input type="checkbox"/> GP <input type="checkbox"/> Specialist: _____	Email: _____
	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Day Hospital
	<input type="checkbox"/> Emergency Dept <input type="checkbox"/> Other _____
Reason for Referral	
Reason for referral: _____	
_____	
_____	
Medical Assessment for Medical Practitioner to complete / PTO for non Medical Referrer	
<input type="checkbox"/> I have attached a summary printout of the client's medical history and current medications.	
Medical Practitioner Signature: _____ Date: _____	
Thank you. No further details required.	
<b>OR:</b>	
<input type="checkbox"/> I have completed the client's medical details <b>overleaf</b>	
Medical Practitioner Signature: _____ Date: _____	

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If faxed: the information contained in this facsimile is confidential and intended solely for the named addressee. The copy or distribution of this communication or information contained in it by anyone other than the addressee is prohibited. If you have received this facsimile in error please contact the author by telephone.

Client Name: \_\_\_\_\_

Client DOB: \_\_\_\_\_

**Medical Conditions (Tick all that apply and provide more information where able)**

- Visual Impairment: \_\_\_\_\_
- Hearing Impairment: \_\_\_\_\_
- Osteoporosis: \_\_\_\_\_
- Musculoskeletal problems: \_\_\_\_\_
- Respiratory disease: \_\_\_\_\_
- Cardiac disease: \_\_\_\_\_ BP reading \_\_\_\_\_
- Psychiatric Condition: \_\_\_\_\_
- Recent surgery: \_\_\_\_\_

**Other relevant Medical Information and Current Medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Exercise Risk Assessment (Tick all that apply)**

- Diabetes – Type I
- Diabetes - Type II Obese
- Poor exercise tolerance < 300m
- Physical Inactivity
- Unstable epilepsy
- Unstable angina
- Poorly controlled hypertension or hypotension
- Severe or poorly controlled cardiac failure
- Poorly controlled complex ventricular arrhythmia
- Other (please specify): \_\_\_\_\_

**Any contraindication to water exercise?**

- Acute infections/febrile conditions
- Vital capacity less than 1.0L
- Severe renal failure
- Incontinence
- Open Wounds
- Within 6 weeks of radiation therapy

**Cardiac Medications (Tick all that apply)**

- Anti-arrhythmics
- Ca channel blocker
- Angiotensin II antagonists
- Beta blockers

- Nitrates
- ACE inhibitors
- Vasodilators
- Other: \_\_\_\_\_

**Functional Assessment (FOR REFERRING THERAPIST TO COMPLETE)**

- I have **attached** a summary printout of the client's rehabilitation to date including a copy of any assessments and details of any home program provided to client.

Referrer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OR:**

- I have completed the functional assessment as below and attached any assessments and details of any home program provided to client:

Referrer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The client can: (please tick those that apply)**

- Stand with:**       no aid       walking aid: Type of aid: \_\_\_\_\_       Carer assist
- Sit to Stand with**       no aid       walking aid: Type of aid: \_\_\_\_\_       Carer assist
- Walk with**       no aid       walking aid: Type of aid: \_\_\_\_\_       Carer assist
- Dress/toilet**       independently       With carer assist

What other services will this patient be accessing? \_\_\_\_\_