



Community Physiotherapy Services

Medical review

Database Number: _____

The following client has been referred to attend, or is attending a Community Physiotherapy Services program. In order to ensure the client is attending the most appropriate program and in the interest of client safety CPS requests the following information:

Client Details	Medical Practitioner details
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Date of Birth: _____	
Phone (Day): _____ (Mobile): _____	Phone: _____
Contact if other than client: Name: _____ Phone: _____	

Community Physiotherapy Services Medical Review

Medical Practitioner to Complete

- I have attached a summary printout of the client's medical history and current medications.

Medical Practitioner Signature: _____

Medical Practitioner Name: _____

Date: _____

Thank you. No further details required. Form completed.

OR:

- I have completed the clients medical details **overleaf**

Medical Practitioner Signature: _____

Medical Practitioner Name: _____

Date: _____

Thank you for completing the form.

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.

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: _____
- Other relevant conditions: _____
- Recent surgery: _____

Results of known investigations/procedures and events that may influence participation in the community setting. Please provide dates and as much detail as possible: _____

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: _____

Other Medications

_____ _____ _____ _____	_____ _____ _____ _____
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Other relevant Medical Information

