



## **AQUATIC THERAPY REFERRAL FORM**

Client Name:

Date of Birth:

Address:

Tel. Number: (H)  
(M)

Client GP/Consultant:

Email address:

Name of Insurance Co:

Self payer Y/N

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History of Present Condition:

Past Medical History:

Social History:

Drug History:

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Aims of Aquatic Therapy:

- 1.
- 2.

Objective Marker e.g. ROM, functional activity

- 1.
- 2.

Subjective Marker e.g. pain score

- 1.
- 2.

## AQUATIC THERAPY HEALTH SCREEN

Name:

Date of Birth:

Date:

<b>ABSOLUTE CONTRAINDICATIONS</b>	Y/N	DETAILS
Acute vomiting or diarrhoea		
Medical instability following an acute episode e.g. CVA, DVT, Status asthmaticus		
Proven Chlorine allergy		
Uncontrolled/Resting angina		
Shortness of breath at rest		
Uncontrolled cardiac failure / paroxysmal nocturnal dyspnoea		
Neutropenia		
Open infected wound		
Weight in excess of 140kg/22 stone		
<b>RELATIVE CONTRAINDICATIONS</b>	Y/N	DETAILS
Acute systemic illness / pyrexia		
Recent radiotherapy/chemotherapy treatment (3/12)		
Known aneurysm		
Poorly controlled epilepsy		
Unstable diabetes		
<b>PRECAUTIONS</b>		
Fear of water		
<b>PRECAUTIONS</b>	Y/N	DETAILS
Skin conditions/eczema/chlorine sensitivity/verruca		
Reduced vital capacity		
Incontinence of urine/faeces		
Epilepsy		
Hypotension		
Renal failure/kidney pathology		
Poor skin integrity/open wound/surgical wound		
Pregnancy (if water temp. $\geq 35^{\circ}\text{C}$ )		
Impaired hearing/vision		
Any other relevant information		

Referring Practitioner

Name:

Tel. No.

Contact Details:

Signature:

*For office use only:*

MYMOP Score

Pre treatment:

Post treatment: