AQUATIC PHYSIOTHERAPY CIRCUITS SELF REFERRAL FORM

PERSONAL DETAILS:

Today's Date: ___/___/____

Name:_____DOB: _____

Name you like to be called: _____

Address: _____
Post code: _____

Home tel. no: _____ Mobile no: _____

Email address:

ABOUT YOU:

Why do you want to use Aquatic Physiotherapy?

_____

_____

_____

Will you be bringing a carer? ☐ Yes ☐ No

Your carer(s) name: _____

Do you need assistance with:

Walking Aid? ☐ **Entering in the pool? (Steps)** ☐

What do you hope to achieve from attending Aquatic Physiotherapy Circuits?

_____

_____

_____

EMERGENCY CONTACT DETAILS:

Name: _____

Relationship to you: _____

Telephone contact number: _____

Address: _____**Post Code:** _____

MEDICAL INFORMATION:

Please make sure you answer every question and tick YES or NO as appropriate. Thank you!

Applicable to you? (Please tick YES or No where appropriate)	**YES**	**NO**	**IF 'YES' PLEASE ELABORATE**
Do you suffer from low blood pressure (Normal is 120/80 - 120 /90)			Controlled? YES ☐ NO ☐
Have you recently suffered a stroke, had a blood clot, heart attack, or a severe asthma attack			(if YES - please elaborate) DATE:
Are you allergic to chlorine?			
Do you get angina attacks at rest?			
Are you or may you be pregnant?			
Do you suffer from shortness of breath at rest?			
Do you have shortness of breath when laying flat?			
Do you suffer from diabetes?			Controlled? YES ☐ NO ☐
Do you suffer from epilepsy?			Controlled? YES ☐ NO ☐
Do you have any open / infected wounds?			
Do you suffer from faecal incontinence?			
Have you had radiotherapy treatment recently (last 6 months)?			
Do you have any fear of water?			
Do you suffer from haemophilia?			
Do you have MRSA?			
Do you have any skin problems, or tubes such as a catheter?			(if YES - please elaborate)
Do you have any ear or eye problems that you feel we should be aware of? (please detail below)			(if YES - please elaborate)

IMPORTANT If you have ticked **'YES'** to any of the questions in RED- you will need to get this form signed by your GP below before attending.

Please provide details of any other medical conditions:

_____

_____

_____

_____

_____

GP USE ONLY:

Please verify below that your patient is safe to use aquatic physiotherapy:

Signature_____

PRINT NAME: _____

Practice/Surgery_____

Date: _____

Contact Number: _____

DECLARATION:

'I have read, understood, and completed this form to the best of my knowledge.'

Signed:_____