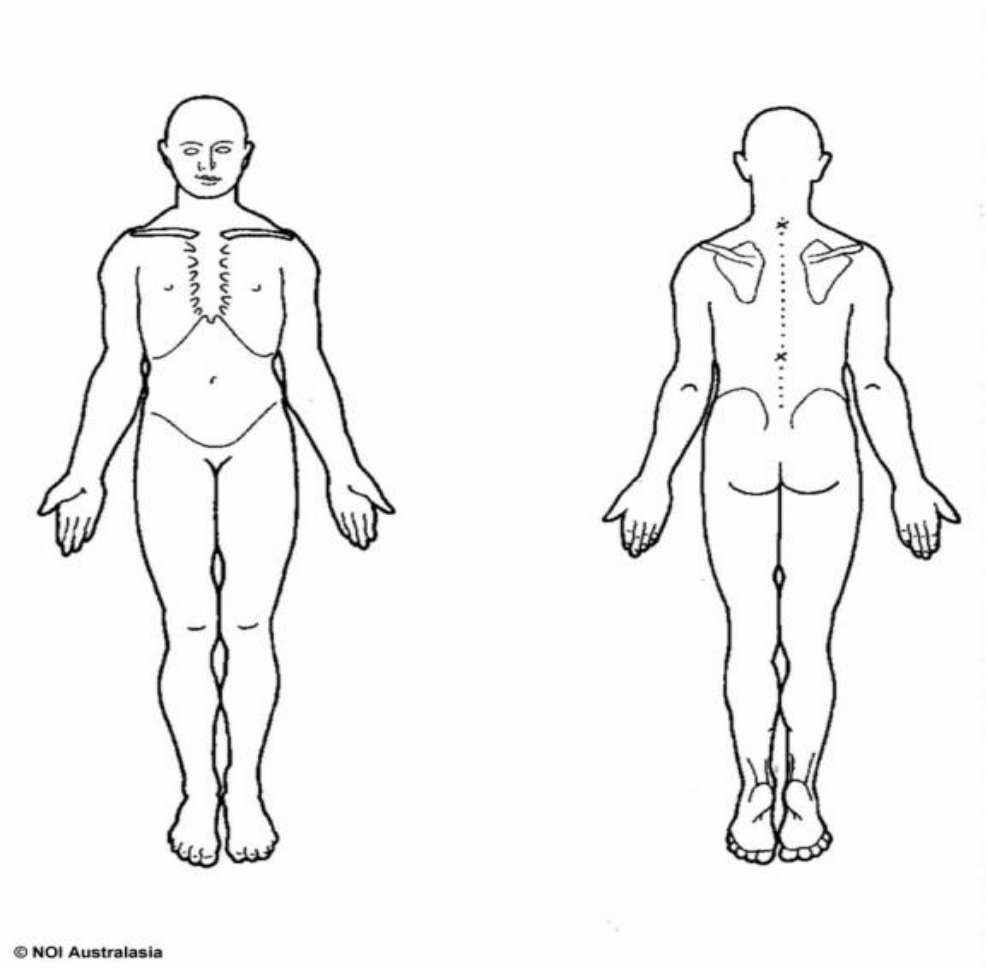
Name:……. **D.O.B……..**

HYDROTHERAPY REFERRAL **Date…….**



HPC

PMH

DH

SH

Objective Assessment

Treatment given

Aims/Objectives/Clinical Reason for Hydro

Review Date:…… Signed:…….……

HYDROTHERAPY HEALTH SCREEN

Date…….

Name: DOB:

Address: Contact Tel No:

Name of Physiotherapist:

CONTRAINDICATIONS	Y/N	CLARIFY
Acute heart failure		
Chronic heart failure Can they lay flat/how many pillows		
Angina		
High BP/low BP		
Recent cerebral haemorrhage		
Uncontrolled diarrhoea		
Acute renal failure		
Uncontrolled epilepsy		
Chlorine sensitivity		
Fever/temp/infection		
Severe behavioural problems		
Past chemo or radiotherapy (when and where)		
PRECAUTIONS	**Y/N**	**CLARIFY**
Diabetes		
Asthma		
Grommets		
Fragile skin		
Fear of water		
High rate of fatigue		
Open wounds/ulcers		
Fungal foot infection		
UTI/Cystitis/Thrush		
Poor eyesight/hearing		
Reduced sensation		
Behavioural issues/agitation/uncontrolled movements		
Antenatal/postnatal		

Patient requirements for hydrotherapy – please complete each section

1. Current level of function:

Dependent w/chair user Sitting balance Y/N
Independent w/chair user Sitting balance Y/N
Independent with aid
Independent

2. Equipment required for transfers:

Molift hoist
Slide board
Rotunda stand
Frame
Elbow crutches
Independent

3. Can the patient complete stairs at present:

Yes
No
N/A

4. Is the patient:

FWB
PWB left/right
TWB left/right
NWB left/right
N/A

Please note: if patients require assistance with changing or transfers they must bring their own carers with them