

**MEDICAL REFERRAL FORM****CLIENT DETAILS:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ PCode: \_\_\_\_\_

Daytime Contact Number: \_\_\_\_\_

1. Goals for participating in this program are:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Improve Balance         | <input type="checkbox"/> Increase Fitness        | <input type="checkbox"/> Increase Flexibility |
| <input type="checkbox"/> Increase Social Contact | <input type="checkbox"/> Prevent Health Problems | <input type="checkbox"/> Increase Strength    |

2. Does the client have any of the following health conditions?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Back Problems     |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Joint conditions        | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Heart Conditions     | <input type="checkbox"/> Neurological conditions | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Chronic pain            | <input type="checkbox"/> Other _____       |

Details of conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Current medication? If yes, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REFERRAL DETAILS:**

Medical Practitioner Name: \_\_\_\_\_

Organisation/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Reason for Referral:

\_\_\_\_\_

\_\_\_\_\_

Providers Signature: \_\_\_\_\_ Date: \_\_\_\_\_