

## ALLIED HEALTH REFERRAL FORM

### CLIENT DETAILS:

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

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

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

1. Regular Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

2. Goals for participating in this program are:

Improve Balance

Increase Fitness

Increase Flexibility

Increase Social Contact

Prevent Health Problems

Increase Strength

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

Asthma

Diabetes

Back Problems

High Blood Pressure

Arthritis

Joint Replacement

Heart Disease

Stroke

Cancer

Osteoporosis

Epilepsy

Other \_\_\_\_\_

4. Current medication? If yes, please list those that may affect client whilst exercising:

\_\_\_\_\_

### REFERRAL DETAILS:

Allied Health Practitioner Name: \_\_\_\_\_

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

I am recommending my client participate in a Strength for life session: Yes No

Reason for Referral: \_\_\_\_\_

Contraindications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recommended strength training exercises/stretchers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that prior to commencing, my client will be prescribed a strength training program, based on the health information and exercise therapy assessment provided

Signature of Provider: \_\_\_\_\_

Date: \_\_\_\_\_