Hydrotherapy Referral

Section A. Background Information

Participant Name:			
NRIC:		**DOB:**	
Contact No.:		**Email:**	
Past Medical History:	☐ None		
Medication(s):	☐ None		
Drug Allergies (if any):	☐ None		
Current Diagnosis:			

Section B. Medical Screening

Does the Client have/experience in the last 1 month:	**No**	**Yes**	**Details**
Chronic Headache/Dizziness	☐	☐	
Cardiac precautions(s)	☐	☐	
Fluid Restrictions	☐	☐	
Chest infection/respiratory exacerbation(s)	☐	☐	
Faecal/Urinary incontinence*	☐	☐	
Epilepsy	☐	☐	
Impaired immunity	☐	☐	
Impaired skin integrity including open wounds	☐	☐	
Impaired cognition	☐	☐	
Indwelling devices e.g. urinary catheters, PEG, tracheostomy, NG tube, etc.	☐	☐	
Contact precautions e.g. herpes zoster, herpes simplex, hepatitis, MRSA, VRE etc.	☐	☐	

*please cancel accordingly

I declare that the following candidate is fit for hydrotherapy.

Name & Signature of Healthcare Professional:	
Date of Referral:	(dd/mm/yy)