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RCH AQUATIC PHYSIOTHERAPY – EXTERNAL REFERRAL FORM

Fax completed referral to – (03) 9345 5034

PATIENT DETAILS

Name: _____ **DOB:** _____

Phone: _____ **RCH MRN (if known):** _____

Address: _____

Referral for NDIS service: YES / NO **If YES, NDIS plan number:** _____

NOK Name and Contact Details: _____

CARE TEAM

Referrer's Name and Role: _____

Child's Paediatrician or Specialist: _____

Child's GP: _____

Other relevant care team members: _____

_____

HISTORY AND CURRENT STATUS

Diagnosis and current history: _____

_____

_____

Relevant past medical history: _____

_____

Current medications: _____

_____

Precautions (eg. WB status in/out of pool, behaviour/cognition, lines, attachments, ROM or other restrictions, immunosuppression, medications)**:** _____

_____

Current function (mobility, transfers, aids, gross motor)**:** _____

_____

Physical assessment findings (e.g. Bailey's AIMs, HiMAT, ROM, strength)**:** _____

_____

PHYSIOTHERAPY GOALS AND PLAN

Ongoing land physiotherapy plan and input: _____

_____

_____

_____

Patient provided with land HEP YES / NO (If YES, please attach)

Aims of aquatic physiotherapy: _____

_____

_____

_____

POOL ACCESS AND SAFETY

Mobility/transfer ability on pool deck (including required aids/assistance)**:** _____

_____

Changing ability in pool area (including required aids/assistance)**:** _____

_____

Method of pool entry exit: Water wheelchair / Hoist / Stairs / Ramp / Pool edge

Falls risk: YES / NO

Independent swimmer: YES / NO **Water confident:** YES / NO

Further considerations and recommended assistance/supervision level for aquatic physiotherapy:

_____

_____

_____

MEDICAL SUITABILITY

Has suitability for aquatic physiotherapy been discussed with and approval given by the child's medical team? YES / NO

If YES, who was this discussed with and approved by (attach correspondence if applicable)

_____

_____

Does the child suffer from seizures? YES / NO

If YES, please attach a copy of the child's seizure management plan.

MEDICAL QUESTIONNAIRE

Does the child have any of the following conditions?		YES	NO
Cardiovascular	Compromised cardiac function		
	↑ or ↓ blood pressure		
	Peripheral vascular disease		
	Aneurysm		
Respiratory	Asthma		
	Cystic Fibrosis		
	Tracheostomy		
CNS	Epilepsy/Seizures		
	Swallowing difficulty		
	Stroke		
	Spinal cord injury		
Airway protection	Ineffective cough		
	Swallowing difficulty		
	Unable to manage thin fluids		
Gastrointestinal	Bowel incontinence		
	Diarrhoea, gastroenteritis in last 14 days		
	Colostomy		
	PRG / NG / NJ		
Genitourinary	Bladder incontinence		
	Urinary tract infection		
Kidney function	↓ kidney function		
Infectious conditions	Airborne infections		
	Herpes simplex virus (e.g. cold sores)		
	Other (e.g. MRSA, VRE)		
Skin	Surgical wounds		
	Skin graft		
	External fixation device		
	Skin rashes or chemical sensitivity		
	Altered sensation		
	Radiotherapy history		
Feet	Tinea / Plantar wards / Fungal nail		
Eyes and Ears	Tubal implants / Grommets		
	Visual impairment		
	Hearing impairment		
	Contact lenses or hearing aids		
	Infections		
Indwelling devices	e.g. Infusaport, IV lines, Hickmans catheter, Intrathecal baclofen pump, PEG		
Thermoregulation	Autonomic dysfunction		
Thyroid dysfunction			
Immunocompromised			
Diabetes			
Pregnancy			
Lymphedema			

Does the child have any other conditions that would be impacted by the physiology of immersion?

_____

_____

_____

_____

If you needed to answer yes to any of the conditions listed on this form please provide details regarding severity, stability and current management.

_____

_____

_____

_____

_____

_____

REFERRAL COMPLETED BY

Signed: _____

Name: _____

Date: _____

Contact Details: _____

_____