Please Fax completed form to **9845 7102**

Therapy Reception, Physiotherapy Department, Westmead Hospital

Patient Sticker

Health
Western Sydney
Local Health District

Physiotherapy Department

HYDROTHERAPY MEDICAL CLEARANCE FORM

This patient is being considered for hydrotherapy as part of his/her physiotherapy program. Please provide medical clearance for this by completing the following form.

Name: ____ Date of Birth: _______________________________

Address: ____

Phone: ____

Condition for which hydrotherapy is requested:

____

Please note absolute contraindications for hydrotherapy:

- ☐ Febrile Conditions
- ☐ Open Wounds
- ☐ Acute infections
- ☐ Genito-urinary incontinence
- ☐ Gastro-enteritis with in the last 10 days *(any condition causing diarrhoea or unpredictable faecal incontinence)*
- ☐ Deep x-ray therapy

Many other conditions would be general precautions for hydrotherapy. With reference to your examination, please comment on the following:

- ➢ Heart Condition: ____
- ➢ Angina (medication): ____
- ➢ Uncontrolled blood pressure (either high or low): ____
- ➢ Dizziness (all the time as opposed to postural etc.): ____
- ➢ Epilepsy (controlled): ____
- ➢ Diabetes: ____
- ➢ Respiratory Conditions: ____
- ➢ Peripheral vascular disease: ____
- ➢ Recurrent middle ear infections: ____
- ➢ Visual impairment: ____
- ➢ Skin condition: ____
- ➢ Pregnancy – 1st trimester: ____

MEDICATIONS:____

____

____

____

I BELIEVE THE ABOVE PERSON IS FIT TO RECEIVE HYDROTHERAPY IF DEEMED APPOPRIATE FOR HIS/HER CONDITION.

Signed: ____ Date: _____________________________