ALLIED HEALTH REFERRAL FORM

CLIENT DETAILS:

Name: _____ Date of Birth: _____

Address: _____ Post Code: _____

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 ❒ Manage Health Problems ❒ Increase Strength

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

❒ Asthma ❒ Neurological Conditions ❒ Back Problems
❒ High Blood Pressure ❒ Joint conditions ❒ Joint Replacement
❒ Cardiovascular Conditions ❒ Cancer ❒ Diabetes
❒ Osteoporosis ❒ Chronic pain ❒ Falls History

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/stretches: _____

_____

_____

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

Signature of Provider: _____ Date: _____