AQUATIC PHYSIOTHERAPY ASSESSMENT FORM

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Date----------

SURNAME---------- Given Names----------

Address----------

----------Postcode----------

Hm Ph---------- Wk Ph/Mob---------- Email/fax ----------

DOB:---------- Occupation ----------

Doctor (GP) ---------- Address/Ph. ----------

----------Specialist ----------

Other Physiotherapist ---------- Ph. ----------

Next of kin----------Contact details:----------

Social Situation: Live alone ☐ Family Support ☐ Stairs in house ☐ Other comments: ----------

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Referred by: please circle one of the following **Friend** **Self** **Doctor** **Physio** **Other**

PAYMENT DETAILS

Will this injury be subject to an insurance claim or legal action? Yes ☐ No ☐

Private patient

Are you a pensioner or on a health care card?----------

Do you have Private Health Insurance for Physiotherapy?----------Fund----------

Payment by another body

DVA Gold Card ☐ or White Card ☐ DVA No:----------

DVA-D904 date:----------

EPC ☐ date of referral: ---------- Drs Prov No:----------

Workcover/CRS/Insurance claim/Other (please state)----------

Claim/File No:----------Contact person----------

Address----------

Ph----------Fax----------Date of accident/injury----------

Workcover-Medical Certificate date:----------

CHECKLIST FOR PRECAUTIONS AND CONTRAINDICATIONS

Yes No

( ) ( ) Heart condition (angina, medication) ----------
( ) ( ) Uncontrolled blood pressure (high or low)----------
( ) ( ) Epilepsy (frequency of fits)----------
( ) ( ) Diabetes----------
( ) ( ) Swallowing problems----------
( ) ( ) Respiratory conditions (shortness of breath, asthma)----------
( ) ( ) Peripheral Vascular Disease----------
( ) ( ) Integrity of skin (broken, ulcers, dressings)----------
( ) ( ) Skin condition (tinea, plantar warts, allergies)----------
( ) ( ) Recurrent ear infections or grommets----------
( ) ( ) Visual impairment----------
( ) ( ) Hearing difficulties (aids)----------
( ) ( ) Acute inflammatory condition (Rheumatoid Arthritis)----------
( ) ( ) Cancer (Radiotherapy/Chemotherapy?)----------
( ) ( ) Genito-urinary tract (infections, incontinence, catheter)----------
( ) ( ) Bowel problems (faecal incontinence, colostomy, recent diarrhoea----------
( ) ( ) Pregnant----------
( ) ( ) Previous surgery----------
( ) ( ) Haemophilia----------
( ) ( ) Contagious diseases (measles, flu)----------
( ) ( ) Contagious diseases Hepatitis, Aids)----------If yes, no pool entry if menstruating
( ) ( ) Family History of any of above----------

Medications: (reason for each)----------

Swimming Ability: ( ) Good ( ) Moderate ( ) Poor Afraid of the water? ( ) Yes ( ) No

Staff Use Only
Pool rules/ safety explained ( ) Fees explained ( ) Patient told to drink ( ) Fatigue explained ( )

Staff signature---------- Date----------

I have to the best of my knowledge given an accurate representation of my medical condition, swimming ability and water safety and agree to advise my physiotherapist if any of the above circumstances change in any way. This is essential as this may change the precautions required or make entry to the pool inappropriate at times. I also accept that there are certain risks involved in any therapeutic activity in water. I have been advised of pool rules and safety guidelines and am aware of factors relating to fatigue and dehydration.

Patient's/Carer's Signature---------- Date----------