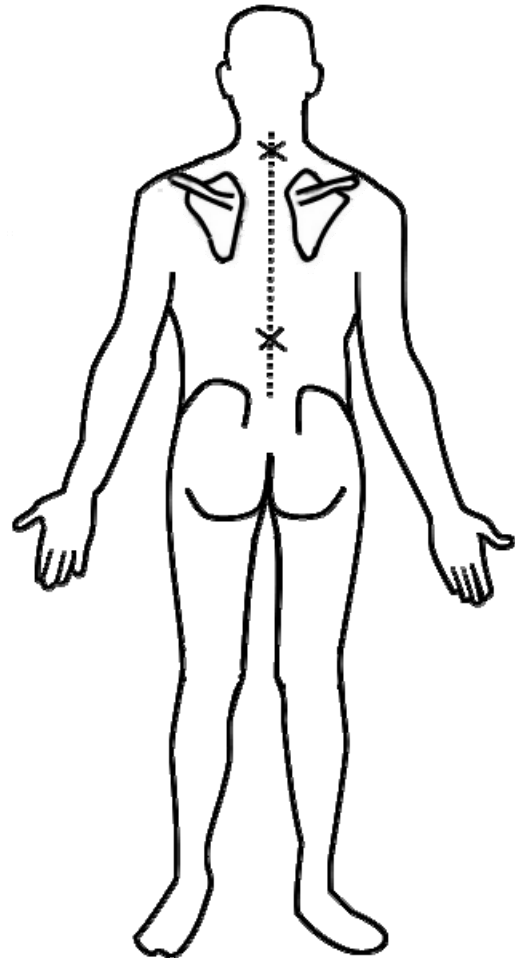
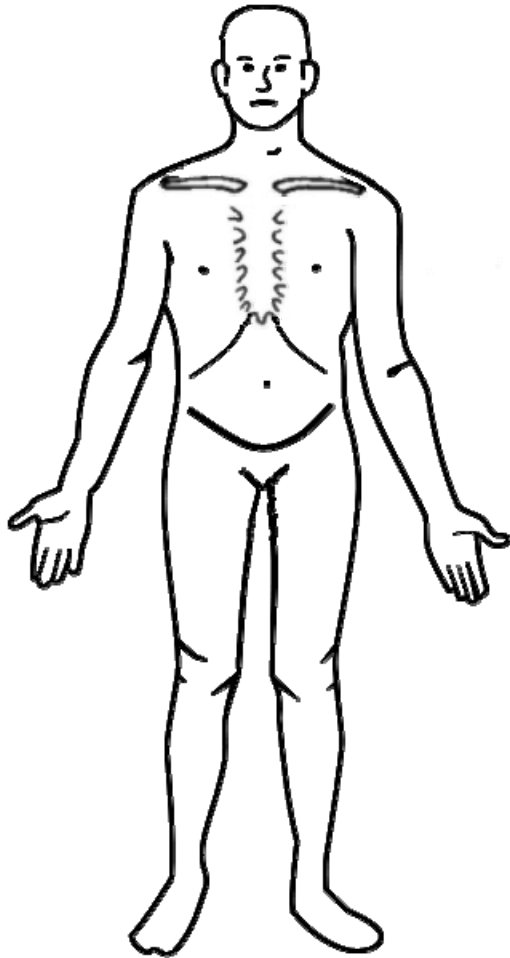


**HYDROTHERAPY REFERRAL**

Date.....



HPC

PMH

DH

SH

Objective Assessment

Treatment given

Aims/Objectives/Clinical Reason for Hydro

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Review Date:..... Signed:.....

Print name & address of referee:.....

**HYDROTHERAPY HEALTH SCREEN**

Date.....

Name:.....

DOB:.....

Address:..... Contact Tel No .....

Group: Lower Limb  
Back

Priority : Urgent  
Routine  
High Risk

Referring Physio:.....

<u>CONTRAINDICATIONS</u>	Y/ N	clarify	<u>SPECIAL QUESTIONS</u>			
Acute heart failure			<u>Anti-Natal</u>		Y/N	clarify
Chronic heart failure Can they lay flat How many pillows			16+ weeks pregnant			
Angina			Scan (all clear)			
High BP/Low BP			? first pregnancy			
Recent Cerebral Haemorrhage			Problems with previous pregnancy(s)			
Uncontrolled diarrhoea			Multiple pregnancy			
Acute renal failure			Bleeding/abnormal discharge			
Uncontrolled epilepsy			History of spontaneous abortion			
Chlorine sensitivity			History of premature labour			
Fever/temp/infection			History of pre-eclampsia			
Severe behavioural problems			Gestational diabetes			
<u>PRECAUTIONS</u>			Foetal growth retardation			
Diabetes			Low lying placenta			
Asthma			Cervical suture/incompetence			
Grommets			<u>Post-Natal</u>			
Fragile skin			6+ weeks post partum			
Fear of water			Bleeding/discharge			
High rate of fatigue			Divarication rectus abdomenus			
Open wounds/ulcers etc			<u>PLEASE NOTE CHANGING/TRANSFER/ASSISTANCE REQUIREMENTS</u>			
MRSA +ve						
UTI/Cystitis/Thrush etc						
Poor eyesight/hearing						
swimmer						