REFERRAL BETWEEN ALLIED HEALTH PRACTITIONERS

Date of referral:

Client name _____ Date of birth _____

Contact details

Client's residential address _____

Phone:_____ Mobile_____

Next of kin: _____ Phone _____

GP _____ GP clinic/medical centre _____

Primary diagnoses and impairments

_____

_____

_____

_____

Mobility: Independent ☐ Assisted ☐ Dependent ☐ Mobility aids _____

Significant activity limitations & participation restrictions identified

_____

_____

_____

Most recent outcome measures relevant to rehabilitation (RUDAS, MBI, DEMMI, TUG, BOOMER, FIM)

_____

Services in situ and service providers involved (including allied health): _____

_____

_____

_____

Client's rehabilitation goals

_____

_____

_____

Relevant history

If attaching an Aged Care Client Record (3020) dated in the last 14 days, this section can be left blank.

History of presenting condition: _____

_____

_____

_____

_____

Past medical & surgical history: _____

_____

_____

_____

_____

Lives alone ☐ Lives with others ☐ Primary carer _____

Social history: _____

_____

_____

_____

Current treatment and exercise program

_____

_____

_____

_____

_____

_____

_____

Referrer details

Name: _____ Position: _____

Email: _____ Phone: _____

Fax: _____ Preferred method of contact: _____

Thank you for choosing Next Step Physio. Please get in touch if you have any particular requests in relation to this client. If you are unsatisfied with the quality of service provided to your client or the format/frequency of feedback provided to yourself, please do not hesitate to raise your concerns.

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