



## HYDROTHERAPY MEDICAL INFORMATION (CLIENT)

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Client: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Carer \_\_\_\_\_

**This form is to be completed by the client's Pediatrician or GP *prior* to entering the pool.**

**DOCTOR'S NAME:** \_\_\_\_\_

Doctor's Contact Phone: \_\_\_\_\_ Contact

Address: \_\_\_\_\_

### **CONTRAINDICATIONS/PRECAUTIONS**

**Please comment on the following ongoing conditions where relevant;**

Has the client been assessed as nil oral?  **Yes**  **No**

Grommets  **Yes**  **No**

Seizures – if yes please comment on the following  **Yes**  **No**

- Type of seizures (grand mal, tonic clonic etc)
- Frequency of seizures
- Predictability
- Medications and associated side effects (&/or recent change)

Myoneural  **Yes**  **No**

Kidney/Renal problems  **Yes**  **No**

Immunosuppression  **Yes**  **No**

Inflammatory Disorder  **Yes**  **No**

Bowel &/or bladder incontinence  **Yes**  **No**

Cardiovascular/Circulatory Problems  **Yes**  **No**

Respiratory condition/Asthma  Yes  No  
Recent CV/Stroke  Yes  No  
Gastrostomy  Yes  No  
Fragile skin  Yes  No

**Please comment on the following temporary conditions where relevant;**

Diarrhea/vomiting  Yes  No  
Infections (vaginal, urinary, ear, eye)  Yes  No  
Skin conditions (tinea, plantar warts)  Yes  No  
Open wounds  Yes  No

Relevant Medications:

Other Comments

I believe that the above client **is/is not** fit to receive hydrotherapy.  
(please circle)

**Doctor's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_