

Doctor's Name: \_\_\_\_\_

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

Post Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Thank you for providing the following information about your patient

\_\_\_\_\_ who wants to join, or is currently part of, our team of hydrotherapy participants. All information is strictly confidential and will only be available to BodyFit NT staff and class leaders. This information is used to provide class leaders with accurate information for exercise prescription and in case of emergency.

Type of arthritis/musculoskeletal condition: \_\_\_\_\_

Part/s of body affected: \_\_\_\_\_

Please mark and comment on any of the following medical conditions which may affect your patient's participation in BodyFit NT's Hydrotherapy Program.

- |  |   |
|--|---|
| <input type="checkbox"/> Abnormal blood pressure _____   | <input type="checkbox"/> Neurological condition _____ |
| <input type="checkbox"/> Cardio-vascular condition _____ | <input type="checkbox"/> Epilepsy _____               |
| <input type="checkbox"/> Respiratory condition _____     | <input type="checkbox"/> Skin condition _____         |
| <input type="checkbox"/> Joint surgery _____             | <input type="checkbox"/> Diabetes _____               |
| <input type="checkbox"/> Other Medical condition _____   |   |

Are there any movements which should be avoided?  Yes  No

If yes, name these movements: \_\_\_\_\_

Are there any medications which should be available?  Yes  No

If yes, name the medication and dosage: \_\_\_\_\_

Does the patient suffer from any allergies?  Yes  No

If yes, name the allergies: \_\_\_\_\_

Does your patient have any other medical consideration which may affect his/her capabilities as a participant in BodyFit NT's Hydrotherapy Program (please see information other side)?

 Yes  No

If yes, explain: \_\_\_\_\_

Is there any other relevant information which might affect treatment in an emergency situation?

\_\_\_\_\_

\_\_\_\_\_

I advise that \_\_\_\_\_ is medically fit to be a participant in the BodyFit NT Hydrotherapy Program.

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please place your stamp opposite. Thank You

Name of Applicant: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Phone No: \_\_\_\_\_

**DECLARATION OF PRIVACY**

BodyFit NT acknowledges and respects the privacy of individuals. This information is being collected for the purposes of processing your application or enquiry, keeping you informed of upcoming events, information and support programs and assisting us in improving our services and programs. The intended recipient of the information is BodyFit NT. The provision of the information is voluntary, but if not provided, we may be unable to process your application or enquiry. You have a right of access to, and alteration of, personal information concerning yourself in accordance with the Act. Please direct any enquires you may have to our Privacy Officer.