AQUASTRETCH™

Referral for Aquatic Services

For the Love of Fit

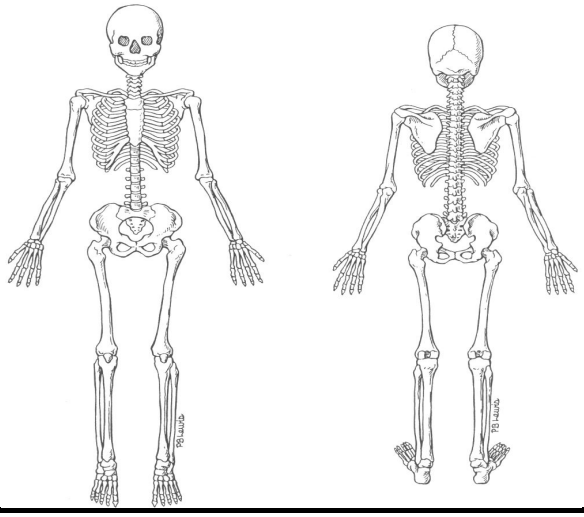
For use by referring health professional:

Patient Name: **Date of Birth:**

Reason for Referral / Goal(s):

Relevant Health Hx:

Area(s) of Injury / Pain:



Please circle / shade all body areas affected.

Notes:

Stage of Treatment: ☐ **Acute** ☐ **Sub-Acute** ☐ **Chronic** ☐ **Pre /** ☐ **Post Surgical** ☐ **Other**

Frequency of Aquatic Services Recommended: ☐ **1 X / Week** ☐ **2 X / Week** ☐ **Other:**

Precautions / Contradictions to *AquaStretch*™ or Aquatic Therapeutic Exercise:			
	☐ Unstable cardiac issues	☐ Fainting / Dizziness	☐ Hypertension
	☐ Uncontrolled diabetes	☐ Seizures	☐ Open skin / stoma
	☐ Recent surgery	☐ Neuropathic pain	☐ Contagious disease
	☐ Recent fracture / tear	☐ Incontinence	☐ Other:

Other Comments:

Print Name of referring health professional: _____

Signature: _____ ***Date:*** _____

Contact number: _____ ***email:*** _____

Physician release / further documentation required & enclosed: ❑ **Yes** ❑ **No**

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