

<u>Procedure for Referring to Hydrotherapy at The Physiotherapy Centre, Holy Cross</u> Hospital, Haslemere.

- 1) Please complete the front sheet with **ALL** the referrer's details so they can easily be contacted if required.
- 2) The Hydrotherapy Health Screen and Referral must be filled in as accurately as possible. Patients access the pool via steps or a hoist please ensure patient transfers and their ability to manage stairs is documented to allow safe access to the pool.
- 3) Referrals should be faxed to 01428 644007 or emailed to therapy@holycross.org.uk
- 4) Once the referral is received we will contact the patient to make a hydrotherapy appointment and explain what they should expect.
- 5) Information regarding the patient's treatment details and progress will be made available to the referrer upon request.

Details of referring physiotherapist:

| - come or research business. | | | | | |
|------------------------------|--|--|--|--|--|
| Name: | | | | | |
| Workplace Address: | | | | | |
| Contact Tel No: | | | | | |
| Email address: | | | | | |
| Signed: | | | | | |

For RSCH only: Is this an NHS referral? YES \square NO \square

*Please note that only one session will be funded by the NHS and all patients being referred should be informed of this prior to referral.

NHS referrals should be emailed to: holy.cross@nhs.net



Hydrotherapy Referral Form

Date:

| Patient details | | | |
|-----------------------------------|----|--|--|
| Name | | | |
| Address | | | |
| DOB | | | |
| Contact telephone number | | | |
| HPC: | | | |
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| PMH: | | | |
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| DH: | | | |
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| SH: | | | |
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| Objective assessment: | | | |
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| Tanakan sakain sa | | | |
| Treatment given: | | | |
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| Aims/clinical reasoning for hydro | D: | | |
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Hydrotherapy Health Screen

| Contraindications: | | No | Please clarify: | |
|--|-----|----|-----------------------------|--------------------------------|
| Acute diarrhoea and vomiting | | | | |
| Medical instability eg. Recent CVA, MI or PE | | | | |
| Resting angina | | | | |
| Shortness of breath at rest | | | | |
| Chlorine allergy | | | | |
| Severe behavioural problems | | | | |
| Precautions: | Yes | No | Please clarify: | |
| Unstable diabetes | | | | |
| Unstable heart conditions | | | | |
| High/Low BP | | | | |
| Poorly controlled epilepsy | | | | |
| Acute systemic illness | | | | |
| During or within 6 weeks of radiotherapy | | | | |
| Known aneurysm | | | | |
| Infected open wounds | | | | |
| Fungal foot infection | | | | |
| · | | | chair user □ nair user □ | Sitting balance: YES □ NO □ |
| Can the patient complete stairs at present? Yes □ No □ Weight bearing status: FWB □ PWB □ TWB □ NWB | | | | |
| Details: | | | | |