BLACKROCK HEALTH
HERMITAGE CLINIC

OUT - PATIENT PHYSIOTHERAPHY

Patient Name: _____ **M** ☐ **F** ☐

Address: _____

DOB: _____

Hospital Number: _____

Phone Number: _____

Email: _____

Diagnosis: _____

_____

Reason for Referral: _____

_____

_____

Precautions (please tick as appropriate):

☐ Pacemaker ☐ Heart Condition ☐ Anti-Coags ☐ Steroids ☐ Diabetes ☐ Osteoporosis
☐ Epilepsy ☐ Infection Control ☐ Resp ☐ Other
☐ Refer to GP

Referring Doctor/Consultant/GP: _____

_____

For Physio Use Only:

Date Received: _____ **Date of first Appointment:** _____

Date contacted: _____

Method of Contact:

☐ Phone
☐ Email
☐ Letter/Appointment card

Presenting complaint: _____

_____

_____

_____

_____

Past Medical/Surgical History: _____

_____

_____

Investigation: _____

_____

_____

Meds: _____

_____

_____

Social History: _____

_____

_____

Family History: _____

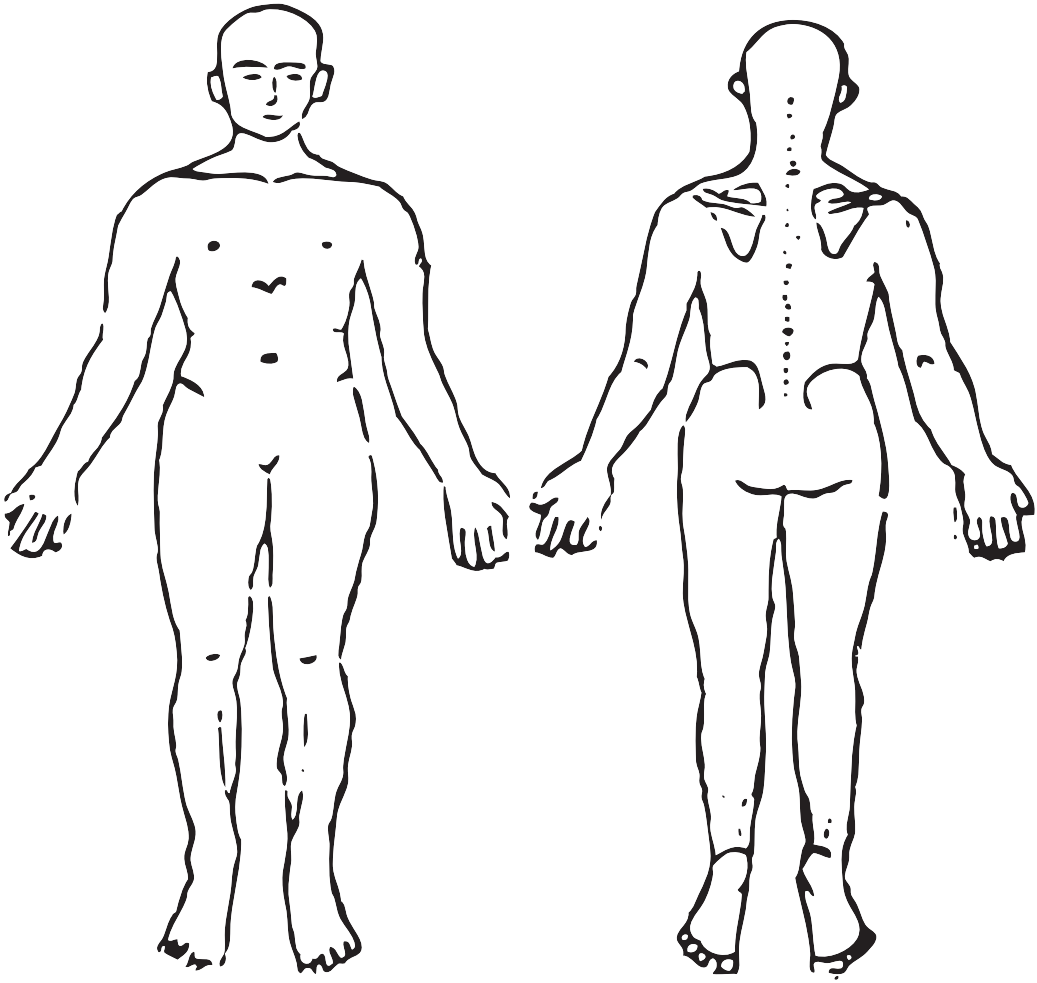
_____

Physio Signature: _____ ISCP No: _____

Physio Print: _____ CORU No. _____

Consent to assessment ☐ Yes ☐ No Risks/side effects of treatment ☐ Yes ☐ No

Consent to treatment ☐ Yes ☐ No Benefits of treatment ☐ Yes ☐ No



S: _____ NRS:

I: _____ Worst: _____

N: _____ Best: _____

PAIN: **Aggravates** _____

_____

Eases _____

AM _____

PM _____

SLEEP _____

Date	No.	Patient Needs/Problem

Date	No.	Patient Specific and Clinical Goals	Approximate number of treatments required	Date Achieved