ability Therapy Place

STROKE REHABILITATION MOBILE CLINIC. BACK PAIN MANAGEMENT MOBILE CLINIC. SPORTS INJURY CLINIC. PAEDIATRIC NEURAL REHAB. SPEECH THERAPY. PROSTHETICS & ORTHOTICS. ERGONOMIC WORKPLACE ASSESMENT. SUPPLIES OF REHAB AIDS & EQUIPMENT HYDROTHERAPY CLINIC.

PAEDIATRIC REHABILIATION REQUEST FORM

Surname _____ Other Names _____

Age _____ Address _____

Referring Doctor _____

Date _____

SERVICES

PHYSIOTHERAPY ☐

- ☐ Chest Physiotherapy
- ☐ Therapeutic Exercises
- ☐ Posture Management
- ☐ Ambulatory

OCCUPATIONALTHERAPY ☐

- ☐ Child Developmental Clinic
- ☐ Sensory Integration
- ☐ School Placement Assessment
- ☐ Cognitive Rehabilitation

SPEECH THERAPY ☐

- ☐ Aphasia Management
- ☐ Delayed speech
- ☐ Swallowing

SPLINTS AND ORTHOTICS ☐

DIAGNOSIS:

RELEVANT MEDICAL HISTORY:

TREATMENT REQUIRED

DOCTOR'S NAME _____ **SIGNATURE** _____

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