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.

REHABILITATION REQUEST FORM

Surname ______________________ Other Names ______________________

Age ______________________ Address ______________________

Referring Doctor ______________________

Date ______________________

SERVICES

PHYSIOTHERAPY ☐

- ☐ Spine/Back Care Clinic
- ☐ Sports Injury Clinic
- ☐ Neuro-Rehab Clinic
- ☐ Ambulatory Physio

OCCUPATIONALTHERAPY ☐

- ☐ Hand Therapy Clinic
- ☐ ADL Training
- ☐ Disability Assessment
- ☐ Cognitive Rehabilitation

PROS/OTHOTICS ☐

- ☐ Splints
- ☐ Prosthetic
- ☐ Orthotic

SPEECH THERAPY ☐

DIAGNOSIS:

RELEVANT MEDICAL HISTORY:

TREATMENT REQUIRED

DOCTOR'S NAME ______________________ SIGNATURE ______________________

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Restoring Health & Function