Strength for Life

COTA AUSTRALIAN CAPITAL TERRITORY

Allied Health Referral Form

Client details

Name ..... **Date of Birth** .....

Address ..... **Post Code** .....

Contact Number ..... **Alternative Contact number** .....

1. Regular Doctor's Name: ..... **Doctor's Phone:** .....

2. Goals for participating in this program are:

- ☐ Improve Balance
- ☐ Increase Fitness
- ☐ Increase Flexibility
- ☐ Increase Social Contact
- ☐ Manage Health Problems
- ☐ Increase Strength

3. Does the client have any of the following health conditions:

- ☐ Asthma
- ☐ Neurological Conditions
- ☐ Back Problems
- ☐ High Blood Pressure
- ☐ Joint conditions
- ☐ Joint Replacement
- ☐ Cardiovascular Conditions
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Chronic pain
- ☐ Falls History

4. Current medication? If yes, please list those that may affect client whilst exercising:

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Referral details

Allied Health Practitioners Name: .....

Organisation/Facility: ..... Phone: .....

I am recommending my client participate in Strength for Life session: ☐ **Yes** ☐ **No**

Reason for referral: .....

Contraindications: .....

Recommended strength training exercises/stretches: .....

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I understand that prior to commencing, my client will be prescribed strength training program, based on the health information and exercise therapy assessment provided.

Signature of Provider: ..... **Date:** .....