Stepping On © Clemson & Swann

'STEPPING ON' referral form

Please fax or email completed form to: Stepping On Project Co-ordinator
***Email*:** info@share.org.au
Phone: 8580 0628 or Mobile: 0499 003 155

Participant details:

Name:	D.O.B: / / Sex: M/F	
Address: Suburb: NSW Post code:		
Home phone: Mobile:		Language spoken:
Falls history: Number of falls or near fall:		
Cognition: (please circle) Intact Borderline Poor Is patient suffering from degenerative neurological condition that affects their ability to participate in interactive group process? YES/ NO		
Precautions:		
Current medication:		
Walking aid:		

- Is patient MEDICALLY STABLE to participate in an exercise program? YES / NO
- Is patient ABLE to participate in testing and any intervention strategies implemented? (i.e.: no severe degenerative disease or cognitive deficits)? YES / NO
- Is patient MOTIVATED to undertake the intervention strategies suggested? YES / NO

Referring Doctor's name: Surgery contact details:	
Signature:	Date:


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