



Stepping On © Clemson & Swann



Health
South Eastern Sydney
Local Health District

'STEPPING ON' referral form

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

