Programs Medical Clearance Form

PART A: To be completed by **PARTICIPANT**

Member number: Name:

Address:

Phone (home): Phone (mobile):

Gender: (Please circle) M F Date of birth:

Can you swim? (Please Circle) Yes (well) Yes (limited) No
(Warm Water Exercise Specific)

Emergency Contact:
Name: Relationship to Participant:

Contact Number:

Current Physical Activity Levels?

	Activity:	Frequency: (how often per week?)	Duration: (how long per week?)
1			
2			
3			

Have you previously attended any hospital or community exercise programs to assist in managing your condition? (if yes, please specify)

What would you like to gain from attending this exercise program?

PART B: Medical Clearance - To be completed by **MEDICAL OFFICER**

Type of arthritis: Joint(s) affected:

Relevant medical history:

Medications:

Current BMI:

Smoking History:

Precautions:

Weight bearing status:

Contraindications to exercise classes

Does your patient have any of the following? (Please answer **every** item)

Part A

Stroke within last 3 weeks (if yes, date__________________)	Y	N
Inflammatory conditions in **acute phase**, e.g. RA, MS, Lupus, Erythematosus	Y	N
Infective skin conditions, e.g. tinea, plantar warts, fungi, impetigo, chickenpox, conjunctivitis, shingles, ringworm	Y	N

NB: If *YES* to any of these conditions, your patient is currently NOT SUITABLE for Land Based Exercise.

Part B

Pregnant/ possibly pregnant?	Y	N
Gynaecological infections	Y	N
UTI	Y	N
Bladder/ bowel incontinence	Y	N
Gastroenteritis	Y	N

NB: If YES to any above in part A PLUS any of the 5 listed as part B, your patient is currently NOT SUITABLE for Water-Based Exercise

Contraindications if uncontrolled

Does your patient have any of the following? (Please answer **every** item)

Open wounds/ broken skin, e.g. psoriasis, dermatitis	Y – controlled	Y – uncontrolled	N
Uncontrolled abnormal blood pressure (please circle: hyper or hypo)	Y – controlled	Y – uncontrolled	N
Thyroid deficiency/ excess	Y – controlled	Y – uncontrolled	N

Cardiac conditions (specify: ________________________)	Y – controlled	Y – uncontrolled	N
Diabetes (please circle: Type I or Type II)	Y – controlled	Y – uncontrolled	N
Documented mental health condition	Y – controlled	Y – uncontrolled	N
Recent major surgery, i.e. cardiac, ortho, neuro specify:	Y -surgeon's consent	Y – no consent from surgeon	N

NB: If *YES - uncontrolled* to any of these conditions, your patient is currently NOT SUITABLE for classes.

Further medical history

Does your patient have any of the following? (Please answer **every** item)

Cognitive impairment (specify: ____________________________________)	Y	N
Respiratory condition (specify: ____________________________________)	Y	N
Renal condition (specify: ____________________________________)	Y	N
Haemophilia, DVT, anticoagulation therapy	Y	N
Steroidal joint injection within 24hr	Y	N
Recurrent middle ear infection	Y	N
Hearing impairments	Y	N
Visual impairments	Y	N
Infectious diseases, e.g. hepatitis, TB, measles, influenza, MRSA, VRE	Y	N
Anaemia/ recent blood transfusion	Y	N
Deep radiotherapy/ chemotherapy in last 3 months	Y	N
Epilepsy or other seizures	Y	N
Osteoporosis	Y	N
Joint replacements (specify: ____________________________________)	Y	N
Recent Hospital Stay (specify: _)	Y	N

NB: If YES to any of these conditions, they MUST be well controlled for your patient to be suitable for classes.

Medications required during class:

Is the patient medically suitable to participate in the suggested exercise class, based on their medical history? Yes No

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Doctor's name: Signature: Date:

Please return to:

Arthritis & Osteoporosis NSW

Address: Locked Bag 2216 NORTH RYDE NSW 1670, Email: gentleexercise@arthritisnsw.org.au

Fax: 02 9857 33