CLIENT REFERRAL FORM

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA
CREATE CHANGE

Adapted Physical Activity Program (APAP)

Please return the referral form to APAP by:

Email: apap@uq.edu.au

Enquiries: Melinda Fenning 0427-876-789

DATE OF REFERRAL :	

CLIENT DETAILS

NAME :		CLAIM NO.
GENDER :	DOB :	AGE :
HOME ADDRESS :		POSTCODE :
MOBILE :	HOME PHONE :	
EMAIL :		
NEXT OF KIN / CAREGIVER	NAME :	
	PHONE :	
NEXT OF KIN/CAREGIVER WILL ATTEND PROGRAM TO ASSIST CLIENT ☐		

CLIENT PROFILE

DIAGNOSIS :
DATE OF DIAGNOSIS/INJURY:

Please choose the option appropriate to your client

COMMUNICATION	☐ VERBAL ☐ NON VERBAL		
MOBILITY	☐ INDEPENDENT ☐ WALKER ☐ W/C ☐ MOTOR W/C ☐ OTHER		
TRANSFER ABILITY	☐ INDEPENDENT ☐ ASSISTED ☐ HOIST		
TOILETING	☐ INDEPENDENT ☐ ASSISTANCE REQUIRED		
TRANSPORT	☐ CAR ☐ ACCESS TO A CAR ☐ PUBLIC TRANSPORT ☐ TAXI		
VISION IMPAIRMENT	☐ NO	☐ YES	AIDS REQUIRED :
HEARING IMPAIRMENT	☐ NO	☐ YES	AIDS REQUIRED
MEMORY IMPAIRMENT	☐ NO	☐ YES	AIDS REQUIRED
EPILEPSY / SEIZURE	☐ NO	☐ YES	DATE OF MOST RECENT EVENT :
USE AN INHALER FOR ASTHMA OR OTHER RESPIRATORY DIFFICULTIES		☐ NO	☐ YES

PHYSICAL ACTIVITY HISTORY

RECREATIONAL/SPORTING INTERESTS :
PAST/CURRENT PHYSICAL ACTIVITY HISTORY :
PHYSICAL ACTIVITY GOALS :
SPECIAL CONSIDERATIONS FOR ACTIVITY :
PHYSICAL LIMITATIONS FOR ACTIVITY :
BEHAVIOURAL LIMITATIONS FOR ACTIVITY :

MEDICAL CLEARANCE: AUTHORITY TO CONSULT MEDICAL PRACTITIONER

NAME OF MEDICAL PRACTITIONER :
NAME OF PRACTICE :
CONTACT PHONE NUMBER :
CONTACT EMAIL ADDRESS :

REFERRAL DETAILS

REFERRER'S NAME :	
POSITION :	
PROGRAM/ORGANISATION :	
MOBILE :	LANDLINE :
EMAIL :	
POSTAL ADDRESS :	POSTCODE :
REFERRER'S GOALS :	

Privacy Statement:

The ADAPTED PHYSICAL ACTIVITY PROGRAM (APAP) complies with Australian and Queensland privacy laws and guidelines. APAP treats information collected as confidential. Information supplied by you will only be used for the administration, educational or research purposes of the University and the School of Human Movement and Nutrition Sciences or in accordance with a specific consent given by you. The Adapted Physical Activity Program will not make available to a third party any personal information supplied by you unless required or permitted by law.

Client participation consent (to be completed by referrer):

I have discussed the APAP program with my client and they have agreed to participate in the program.

SIGNATURE_____ DATE _____/_____/_____