

Referring Health Professional Details

Name: _____

Role / Profession: _____

Clinic / Organisation: _____

Phone: _____

Email: _____

Client Details

Full Name: _____

Date of Birth: ____ / ____ / ____

Phone: _____

Email: _____

Home Address: _____

Suburb: _____

SAH Package Level: _____

Care Manager Details

Name: _____

Position: _____

Phone: _____ Email: _____

SAH Provider Organisation: _____

Reason for the Referral

- | | |
|---|---|
| <input type="checkbox"/> Reduced Mobility | <input type="checkbox"/> Neurological Condition |
| <input type="checkbox"/> Post-surgical Recovery | <input type="checkbox"/> Falls Risk |
| <input type="checkbox"/> Pelvic Floor Physiotherapy | <input type="checkbox"/> Elderly Continence Support |
| <input type="checkbox"/> Prolapse Symptoms | <input type="checkbox"/> Pelvic Health Education |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Other: _____ |

Pelvic Health / Women's Health Concerns

- | | |
|---|--|
| <input type="checkbox"/> Bladder Leakage | <input type="checkbox"/> Pain with Intercourse |
| <input type="checkbox"/> Urgency / Frequency | <input type="checkbox"/> Pelvic Girdle Pain |
| <input type="checkbox"/> Constipation / Bowel Dysfunction | <input type="checkbox"/> Menopause-related Pelvic Symptoms |
| <input type="checkbox"/> Pelvic Organ Prolapse | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pelvic Pain | |

Current Support in Place

- | | |
|---|--|
| <input type="checkbox"/> Partner / Family Support | <input type="checkbox"/> Aged Care Package |
| <input type="checkbox"/> Support Worker | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Community Nursing | |

Goals for Shared Care / What You'd Like Us to Focus On

- | | |
|--|--|
| <input type="checkbox"/> Pelvic Floor Rehabilitation | <input type="checkbox"/> Strength and Movement |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Falls Prevention |
| <input type="checkbox"/> Safe Return to Daily Activities | <input type="checkbox"/> Return to Exercise |
| <input type="checkbox"/> Mobility Retraining | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bladder and Bowel Management | |

Urgency

- Urgent (with in 1- 2 weeks)
- Semi Urgent (with in 3 - 6 weeks)
- Non Urgent

Preferred Appointment Type

- Home Visit
- Telehealth Support
- Hybrid Home + Onsite Clinic Care
- Onsite Clinic

Referrer Signature:

Date: ____ / ____ / ____

Please send referral to:

Body Sync Physiotherapy

Physiotherapy | Pelvic Health | Women's Health | Clinical Pilates | Rehab