# Kids Medical Clearance

Dear Doctor,

Your patient would like to participate in exercise therapy with a Physiotherapist &/or Exercise Physiologist at NeuroMoves. Given the complex health conditions that we see at NeuroMoves and the intensity and type of exercise therapy we may provide, we request a medical clearance every 24 months, or earlier due to a major change in medical status. Such clearance assists us in ensuring that we provide the most effective and safe modalities of therapy to help our clients achieve their goals.

| **Patient Details** | |
|---|---|
| First Name: | Surname: |
| Date of Birth: | |
| Address: | |

| **Please tick all the following modalities in that you do provide clearance for your patient to participate in:** | |
|---|---|
| **Load bearing exercises:** | ☐ **Yes** ☐ **No** |
| **Body weight support treadmill training:** | ☐ **Yes** ☐ **No** |
| **Hydrotherapy:** | ☐ **Yes** ☐ **No** |
| **Functional Electrical Stimulation:** | ☐ **Yes** ☐ **No** |

| **Additional Recommendations** | |
|---|---|
| Current medication summary attached: | ☐ Yes ☐ Not relevant |
| Current relevant medical history attached: | ☐ Yes |
| Additional Recommendations/precautions for this client. Please outline: | |

| **Your information** | |
|---|---|
| Name: | *Place Doctor stamp here with your provider number:* |
| Signature: | |
| Provider Number: | |
| Date: | |

Please give the completed report to your patient or send to info@scia.org.au or fax (02) 7202 0944.

If you wish to discuss further, please do not hesitate to contact NeuroMoves on 1800 819 775