

## Medical Clearance

Dear Doctor,

Your patient is currently participating in exercise therapy with a Physiotherapist and/or Exercise Physiologist at NeuroMoves. Given the complex health conditions 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 Part 1 and 2, that you provide clearance for your patient to participate in

Part 1: Load Bearing Exercises	
Load Bearing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Exercises that can involve load bearing to the limbs. Such exercises may be performed out of the wheelchair. Involving but not limited to: <ul style="list-style-type: none"> <li>○ Cardiovascular exercises (e.g.: arm ergo, boxing)</li> <li>○ Body Weight Supported Treadmill Training</li> <li>○ Load bearing (partial and full) in different positions including standing, kneeling, crawling</li> <li>○ Repetitive task- specific exercises</li> <li>○ Gait and balance training</li> <li>○ Bed mobility and sitting balance</li> <li>○ Strengthening exercises</li> </ul>
Part 2: Other Modalities	
Hydrotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Warm water-based exercises to assist with increasing muscle strength, reduce muscle/joint stiffness and pain, and therefore increasing mobility.
Functional Electrical Stimulation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Use of electrical currents to activate paralysed, weak, or spastic muscles to improve functional movements such as sit to stand, reaching, or walking. Can be utilised in a cycling type activity or in isolation.
Wheelchair based/seated exercises: <input type="checkbox"/> Yes <input type="checkbox"/> No	Strength & conditioning exercises (e.g., weight machines, TheraBand, dumbbells, medicine balls): <ul style="list-style-type: none"> <li>○ Cardiovascular exercises (e.g., arm ergo, boxing)</li> <li>○ Motor control exercises involving balance (e.g., throwing, catching)</li> <li>○ General mobility training (e.g., transfer specific, stretching)</li> </ul>

<b>Part 3: Blood Pressure Monitoring</b>	
Current resting BP:	_____/____ mmHg, _____ HR
At NeuroMoves, our cut off BP to commence exercise is 160/100mmHg. If you are happy for your patient to exercise above this threshold, please inform the desired maximum BP.	_____/____ mmHg, _____ HR <b>OR</b> <input type="checkbox"/> <u>No</u> BP Issues
Monitoring of BP during exercise:	<input type="checkbox"/> Monitoring of BP is required pre or post exercise <b>OR</b> <input type="checkbox"/> <u>No</u> monitoring of BP is required pre and post exercise
<b>Additional Recommendations</b>	
Current medication summary attached:	<input type="checkbox"/> Yes
Current relevant medical history attached:	<input type="checkbox"/> Yes
Additional recommendations for this client. Please outline:	
<b>Your information</b>	
Name:	<i>Place Doctor stamp here with your provider number:</i>
Signature:	
Provider Number:	
Date:	

Please give the completed report to your patient or send to [info@scia.org.au](mailto: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.