Stepping On © Clemson & Swann

Health
South Eastern Sydney
Local Health District

‘STEPPING ON’ referral form

Please fax or email completed form to: Stepping On Project Co-ordinator
Email: SESLHD-steppingon@health.nsw.gov.au or fax: 95408292
before starting the program

Participant details:

Name:	D.O.B: / / Sex: M/F
Address: Suburb: NSW Post code:	
Home phone: Mobile:	Language spoken:
Falls history: Number of falls or near fall:	
Cognition: (please circle) Intact Borderline Poor Is patient suffering from degenerative neurological condition that affects their ability to participate in interactive group process? YES/ NO	
Precautions:	
Current medication:	
Walking aid:	

- Is patient MEDICALLY STABLE to participate in an exercise program? YES / NO
- Is patient ABLE to participate in testing and any intervention strategies implemented? (i.e.: no severe degenerative disease or cognitive deficits)? YES / NO
- Is patient MOTIVATED to undertake the intervention strategies suggested? YES / NO

Referring Doctor’s name: Surgery contact details:	
Signature:	Date: