REFERRAL FOR AquaStretch™ SERVICES

Patient Name: ______________________ **Date of Birth:** ______________

Emergency Contact: **Phone:**

Reason for Referral:

History of Recent Injury?

Area of Injury / main complaint:

Stage of Treatment:	❑ Acute ❑ Sub-Acute ❑ Chronic ❑ Post Surgical	***Frequency of AquaStretch™ Recommended:***	❑ Every 14 days ❑ 1 / week ❑ 2 / week ❑ Other:______________________

Precautions / Contraindications for AquaStretch™ - *Check all existing issues & Indicate whether medical clearance has been given*

Medical Clearance given? Indicate 'yes' or 'no' after each issue checked:

- ☐ Soft Tissue Tears
- ☐ Joint laxity
- ☐ Breaks (fractures)
- ☐ ≤ 3 months post-op
- ☐ Long-term steroid use
- ☐ Edema of unknown cause (should get medical clearance first)
- ☐ Heavy meds or substance abuse
- ☐ Litigation cases
- ☐ Joint replacement
- ☐ Osteoporosis
- ☐ Anticoagulant medications (possible bruising)
- ☐ Not responsive first treatment (example: hydrophobic, FMS)

Other Contradictions to AquaStretch™ Based on Treatment / Past Medical History?

Other Comments:

Name & Title of Healthcare Professional:

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Referral Date

Signature of Referring Healthcare Professional

Physician Referral Enclosed ❑ **Yes** ❑ **No**