Constraint Induced Movement Therapy Referral Form

Name of person completing referral: _____

(If you are not the client)

Relationship to client: _____

Phone contact: _____

Do you have the client's consent to refer: Yes No

Does the client understand the requirements of the program: Yes No

CLIENT INFORMATION:

Name: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Email: _____

Gender: _____ Date of Birth: _____ Age: _____

Alternate contact person: _____ Phone: _____

GP name: _____ Practice: _____ Phone: _____

Rehabilitation Specialist Name: _____ Place of work: _____

Diagnosis (please circle): Stroke Brain Injury Brain Tumour

Approximate date of diagnosis: _____

Affected hand (please circle): Right Left Dominant hand (please circle): Right Left

YOUR WEAK ARM:

Please answer questions 1-3 with the weaker forearm resting on the arm of a chair, with the wrist bent downward and the hand hanging loosely over the front edge of the armrest.

1. Can you bend your wrist back without lifting your forearm? Yes No
2. Can you open your hand? Yes No
3. Can you move your thumb away from the palm of your hand? Yes No

For questions 4-7, your arm does not need to be in any special position.

4. Can you straighten your elbow? Yes No

5. Can you touch your chin with your weak hand and return it to your lap? Yes No

6. Can you raise your arm at the shoulder? Yes No

7. Can you pick up a washcloth and release it? Yes No

8. Do you have pain in your arm when resting? Yes No

9. Do you have pain in your arm when moving? Yes No

YOUR FUNCTION:

1. Can you walk by yourself either with or without an aid? Yes No

Walking aid (if used): _____

2. Can you go to the toilet by yourself? Yes No

Equipment needed (if applicable): _____

Which clinic locations would you consider attending (tick all that apply):

☐ Prince of Wales Hospital, Randwick

☐ St George Hospital, Kogarah

☐ Sutherland Hospital, Caringbah

Do you understand the requirements of the program and are you willing to complete the full program? Yes No

Please return completed form by email to:

SESLHD-Sutherland-CMTReferrals@health.nsw.gov.au