Gleneagles™ HONG KONG 港怡醫院

Physiotherapy Referral Form

Patient Label

Patient name: ______________________   Age / Sex: ______________________

Diagnosis: ____

Recommended Frequency of Treatment: ______________________________

Recommended Treatment:

- ☐ Chest Physiotherapy
- ☐ Pain Relief
- ☐ Walking Training (NWB / PWB / FWB)
- ☐ Strengthening
- ☐ Cardiac Rehabilitation
- ☐ Woman's Health
- ☐ Postural Assessment
- ☐ Neuro Rehabilitation
- ☐ Core Muscle Training
- ☐ Weight Management
- ☐ Vestibular Rehabilitation
- ☐ Stretching Exercise
- ☐ Others: ______________________________

Prescription of Equipment:

- ☐ SP Walker
- ☐ Donjoy Ultrasling
- ☐ Armsling
- ☐ XP walker + / - Heel raise
- ☐ Hinge Knee Brace
- ☐ Knee Support
- ☐ Ankle Support
- ☐ Criss Cross Corset
- ☐ Abdominal Binder
- ☐ Carpal Tunnel Splint
- ☐ Wrist Splint
- ☐ Triflow
- ☐ Others: ______________________________

Date : ______________________   Signature of Dr.: ______________________

Address: 1 Nam Fung Path, Wong Chuk Hang, Hong Kong   Contact No : 3153 9141   Fax No : 3903 3459