MOBILITY ACTION PROGRAM REFERRAL

Client Name:

DOB: **NHI#**

Address:

Phone Hm: **Mob:**

Referring GP:

Practice Name:

Community Service Card YES / NO

General Entry Criteria Checklist - *Please tick where appropriate*

Is the client aged between 40 and 65 ☐

Suffers from:
Osteoarthritis (OA) ☐
Rheumatoid Arthritis (RA) ☐
Low back pain (LBP) ☐

Primary disability is in a joint of the:
Lower limb ☐
Lower back ☐

Confirm the condition above is not covered by ACC or another insurer/funder ☐

Confirm the patient been experiencing disability for a duration longer than **3 months** ☐

Confirm the patient is not currently waiting for a First Specialist Assessment (FSA) or surgery for the condition ☐

Confirm the patient is able to participate in exercise and has no uncontrolled underlying health conditions ☐

If the patient does not hold a community services card, would the patient be willing to contribute towards their rehabilitation ($25 surcharge for each visit; assessment and treatment (max 10 visits ☐

GP Sign: _____ Date: _____

Please send via: **Email: admin@bimphysio.co.nz Healthlink: bodynmot**
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