

## Medical Clearance Form

Movement Disorders Clinic/Medical Practice details:

**RE:**

Patient Name

**DOB:**

**Phone Number:**

**Condition:** Parkinson's disease/related condition. Please specify:

I confirm that the above patient is medically fit to participate in:

- An intensive voice therapy program e.g. SPEAK OUT!/ LSVT.

*The SPEAK OUT! program consists of initial assessment and education sessions followed by intensive individual speech therapy sessions. (Usually 3 sessions/week for 4 weeks). A weekly group maintenance program follows.*

Speech Pathologist: Karen Malcolm. Medicare Provider Number 5727131J

Speech Pathologist: Cathy Shapter. Medicare Provider Number 5624621B

Speech Pathologist: Louise Williams. Medicare Provider Number 4168365H

Contact details: Mob 0438 688 456; Email [info@rhpththerapy.org.au](mailto:info@rhpththerapy.org.au)

Signed:

Movement Disorder Specialist/ GP

Date:     /     /

**IMPORTANT Please attach the following information:**

- HEALTH SUMMARY SHEET (Including MEDICATION SUMMARY)**
- Movement Disorder Specialist letters/reports**
- MoCA or other cognitive assessment results**