restoring hope Parkinson's therapy

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Referral and 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@rhptherapy.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**