

## Ira May Aquanatal Canberra Medical Clearance Form (ante-natal)

**Please take this form to the obstetrician, doctor or midwife who is looking after you. You will require their consent *before* you can participate in Aquanatal® exercise classes.**

**Aquanatal®** classes are specifically tailored to the needs of pregnant women and run by specially trained **Aquanatal®** instructors, who are midwives, physiotherapists or other health professionals. **Aquanatal®** is generally suitable for healthy women from 14 weeks of pregnancy. A collection of research-based information on **Aquanatal®** exercise and exercise in pregnancy is available on the **Aquanatal®** website at <http://www.aquanatal.com.au>.

To the healthcare provider: Please review your client and indicate whether she is, or is not, able to participate safely in a regular **Aquanatal®** exercise program.

### Client

Name: _____
Client's Birthdate: _____ Baby's due date: _____

### Does your client have any of these conditions?

1) Ruptured membranes or premature labour	No	Yes	9) History of miscarriage or premature labour	No	Yes
2) Pregnancy-induced hypertension or pre-eclampsia	No	Yes	10) Anaemia or iron deficiency (Hb < 100 g/L)	No	Yes
3) Incompetent cervix	No	Yes	11) Malnutrition or eating disorder (anorexia, bulimia)	No	Yes
4) Persistent second or third trimester bleeding	No	Yes	12) Any cardiovascular or respiratory disease (e.g. chronic hypertension, asthma)	No	Yes
5) Placenta previa	No	Yes	13) Other significant medical condition(s)	No	Yes
6) Possible intra-uterine growth restriction	No	Yes	Please specify: _____		
7) Multiple pregnancy (e.g. twins/triplets)	No	Yes	_____		
8) Uncontrolled Type I diabetes, hypertension, thyroid disease	No	Yes	_____		

### Physical Activity Recommendation

I hereby approve <b>Aquanatal®</b> exercise programs for my client _____	[insert client name]
Additional comments: _____	
_____	
Name of healthcare provider: _____	
Address: _____	
Telephone: _____	
Signed: _____	Date: _____