Royal Rehab
Empowering Independence

Be Pain Smart Clinic

Referral Date: _____

Referral to Be Pain Smart Clinic (Brain and Spinal Injuries)

Address:

Ph Number: **Mobile:**

Email:

Surname: .....

Given Names: .....

MRN (If current Royal Rehab client) .....

DOB: .....

Medicare No:

Next of Kin/Alternative Contact
Name: **Relationship:** **Phone Number:**

Country of Birth: **Interpreter Required: No** ☐ **Yes** ☐ **Language:**

Gender: Male ☐ Female ☐ Non-binary ☐ Prefer not to say: ☐

Is the client Aboriginal/Torres Strait Islander?

Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐

Neither Aboriginal nor Torres Strait Islander ☐ Unknown ☐

GP Name: **GP Phone No:** **GP Fax No:**

Client Marital Status: Single (never married) ☐ Widowed ☐ Divorced ☐ Separated ☐
Married/De Facto ☐ Unknown ☐

Lives: Alone ☐ With Spouse/Partner ☐ With Parents ☐ Other Family Member ☐

Other ☐ _____

Referring Service: **BIRP** ☐ **SSCIS** ☐ **iCARE** ☐ **COMMUNITY/GP** ☐ **LOCAL REHAB SPECIALIST** ☐

Contact Name, address and Contact Details of Referring Service:

Treating Acute Service:

Has the client participated in an inpatient rehabilitation program?

Yes ☐ Current ☐ Discharged ☐ Name of Service: _____

No ☐ Second Service (if applicable): _____

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royalrehab.com.au

SURNAME: GIVEN NAME: DOB:

Funding: Public ☐ NSW CTP ☐ iCare LTCS ☐ iCare Workers Care ☐ Workers Comp ☐

Interstate Motor Vehicle compensation ☐ NDIS ☐ My Aged Care ☐ Other Chargeable ☐

Claim/Reference #: _____

Claim Status: Not lodged ☐ Pending ☐ Interim ☐ Compensable ☐ Non-compensable ☐ Unknown ☐

Contact Details: (NDIS Support Coordinator /Case Manager/Insurance Co-ordinator etc):

Date of Injury:

Dual Diagnosis **Yes** ☐ **If yes please complete both sections** **No** ☐

Spinal Referrals Only

Rehabilitation Specialist:

LEVEL OF INJURY:	**AIS SCORE:** ☐ **A** ☐ **B** ☐ **C** ☐ **D** ☐ **E**

Cause of Injury:	MVA ☐	Non- MVA ☐	
	Motor vehicle occupant ☐ Unprotected land transport user ☐	Fall ☐	Low fall ☐ High fall (≥1 metre) ☐
	Other ☐ (specify):_____	Water-related ☐ Horse-related ☐	Heavy falling object ☐ Football ☐

Spinal Medical Review completed in the last 12 months ☐ Yes ☐ No

Brain Injury Referrals Only

Rehabilitation Specialist:

Type of Injury:	TBI ☐	Non- TBI ☐
Cause of Injury:	MVA ☐ Non-MVA ☐ **Non-MVA categories:** Push bike/Scooter/skateboard/wheelchair ☐ Fall ☐ Assault ☐ Sport related ☐ Fall from horse ☐ Gunshot ☐ Other ☐ Unknown ☐	Hypoxia ☐ Stroke ☐ Infections ☐ Other non-TBI ☐ specify)_____ Unknown ☐

PTA - Did the patient experience PTA? Yes ☐ No **Duration of PTA (days)**:_____

PTA range: <24 hours (mild) ☐ 1-7 days (moderate) ☐ 8-28 days (severe) ☐ 29-90 days (very severe) ☐

91-183 days (very severe) ☐ >=184 days (chronic amnesic state) ☐

SURNAME: GIVEN NAME: DOB:

REASON FOR REFERRAL TO BE PAIN SMART CLINIC

PROMIS-29 FORM completed and attached to the referral Yes ☐ No ☐

Please identify the areas of current pain or concern

☐ Head	☐ Neck	☐ Chest	☐ Back
☐ Shoulder ☐ Left ☐ Right	☐ Arm ☐ Left ☐ Right	☐ Hand ☐ Left ☐ Right	☐ Abdomen
☐ Thigh ☐ Left ☐ Right	☐ Pelvic/Genital	☐ Buttocks ☐ Left ☐ Right	☐ Hip ☐ Left ☐ Right
☐ Knee ☐ Left ☐ Right	☐ Foot ☐ Left ☐ Right	Other	Other

Other co-morbidities/complexities

_____
_____
_____
_____

Why are you referring this client to the BPS clinic?

_____
_____
_____
_____
_____
_____

Has there been any acute change in health condition over the past 6 weeks? If yes please outline below

_____
_____
_____
_____
_____

Other Information – Please indicate which other services are/will be involved with client

_____
_____
_____
_____
_____

Please include all relevant paperwork to support the referral including discharge summaries, investigations, scan results and any other relevant reports that will assist in reviewing this referral.

SURNAME: GIVEN NAME: DOB:

List any **RISKS** that there might be for staff (i.e. behavioural concerns, infection risks etc):

CONSENT - MUST be completed by referee for the clinic to accept the referral

I have discussed a referral to the Be Pain Smart Clinic and client has given verbal consent to be contacted regarding this referral by the Be Pain Smart Clinic ☐

Referred By (Name and designation): _____

Submit Referral by: Fax (02) 8415-8902 OR Email: bepainsmart@royalrehab.com.au