NSW Brain Injury Rehabilitation Program – Referral Form to the metropolitan units

Date of Referral: _ _/_ _/ 20_ _ **Date of Injury _ _/_ _ / 20_ _**

Referral Made by

WESTMEAD BRAIN INJURY REHABILITATION PROGRAM	☐
Address:	**PO Box 533 Wentworthville NSW 2145**
Contact Nos:	**Phone: (02) 9845 7941 Fax: (02) 9635 8892**
Director / Coordinator:	**Dr. Joe Gurka**

ROYAL REHABILITATION CENTRE SYDNEY	☐
Address:	**PO Box 6 Ryde NSW 2112**
Contact Nos:	**Phone: (02) 9809 9023 Fax: (02) 9809 9027**
Director / Coordinator:	**Dr. Clayton King**
Referral Coordinator	**Amanda Buzio**

LIVERPOOL BRAIN INJURY REHABILITATION UNIT	☐
Address:	**Brain Injury Rehabilitation Unit Locked Bag 7103 Liverpool BC NSW 1871**
Contact Nos:	**Phone: (02) 9828 5495 Fax: (02) 9828 5494**
Director / Coordinator:	**Dr. Adeline Hodgkinson**

CLIENT DETAILS

Name:	**DOB:** _ _ / _ _/ _ _ _	**MRN:**
	MEDICARE NUMBER	
Address:	**Phone:**	
Current Location: (eg. St George Hospital)	**Ward:**	**Referred By:**
	AMO:	**Position:**
	Phone:	**Phone:**

Interpreter Needed:	**Yes** ☐	**No** ☐	**Language:**	**Permanent Australian Resident:**	**Yes** ☐	**No** ☐

INJURY INFORMATION

Cause:	**Hospital/s:**		
Date of Injury:	**PTA:**	**LOC:**	**Previous Rehabilitation:**

INVESTIGATIONS PERFORMED:

Cerebral CT / MRI	**Yes** ☐	**No** ☐	**Other:**

History of Injury		**Nature of TBI**		**Cerebral CT findings:**
MVA/MBA/PBA	☐	Contusion/ICH	☐	
Pedestrian	☐	SDH/EDH/SAH	☐	
Assault	☐	Hypoxic	☐	
Industrial/Work	☐	Skull #	☐	
Fall	☐	Other Injuries	☐	
Other/Unknown	☐	Describe other injuries:		

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GCS-Admission		**GCS – Time of referral**						
Loss of Consciousness:	Not Known	☐	No	☐	Yes	☐	Period:___	
Neurosurgery:	No	☐	Yes	☐	**Date & Description:**			
Tracheostomy:	**No**	☐	**Yes**	☐	**Date in:** _ _ /_ _ /_20 _ _		**Date Out** _ _ /_ _/20_ _	
PTA	**Out of PTA**	☐	**In PTA**	☐	**Unknown**	☐	**Period:**	

Neurological Deficits:

Other Medical / Surgical Problems:

Behavioural Problems	Nil	☐	Wander	☐	Req. Restraint	☐	Aggressive	☐
Nutrition	Normal	☐	Oral Modified	☐	NG feeds	☐	PEG feeds	☐
Mobility	Nil	☐	Can stand/assist	☐	Non/Part/Full Weight	☐	Walk/Assist/ Independent	☐
Bladder	Continent	☐	Incontinent	☐	IDC	☐	Uridom	☐
Bowel	Continent	☐	Incontinent	☐	Wound Infection	Nil ☐	Yes	☐
Infection Site:	MRSA	☐	Pressure Ulcers	Yes ☐	Nil	☐	Pressure scores	

Please assess the following suitability criteria for admission (SCA)
1. Not yet (medically unstable, awaiting further procedure etc.) – date of the planned procedure if known:_ _ /_ _ / 2 0 _ _
2. Ready but low level requiring heavy nursing care
3. Ready but behaviour problems requiring close supervision
4. Out of PTA or almost out of PTA, can manage self-care at home, consider discharge for Community team follow up

UPDATE:

Notes: _ Date: ___________ **SCA** ☐

_ _

Notes: _ Date: ___________ **SCA** ☐

_ _

Notes: _ Date: ___________ **SCA** ☐

_ _

Notes: _ Date: ___________ **SCA** ☐

_ _

Notes: _ Date: ___________ **SCA** ☐

_ _

5. Suitable for admission **No** ☐ **Yes** ☐

Admit: **No** ☐ **Yes** ☐ **Date**: _____________ **W/List** ☐ **Referral to**: _____________________________

Reasons____

Referring clinician notified	**Date: _ _ / _ _ / _ _ _ _**
Referral Form Completed By:	
Referral Entered in the Referral Database:	**Date: _ _/_ _ /_ _ _ _**