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| logohorizontal-1500px  **SOUTH AUSTRALIAN BRAIN INJURY REHABILITATION SERVICE**  **INPATIENT /**  **CONCUSSION TBI, OPD CLINIC REFERRAL** | | | | | | | Surname:  Given Name:  MRN No:  Address:  DOB: Age:  *Please affix patient Label Here* | | | | | | | | | | | | | |
| **INPATIENT  CONCUSSION / OPD TBI CLINIC**  **\*\*\* For SABIRS Outpatient Medical Appointment only please complete M60** | | | | | | | | | | | | | | | | | | | | |
| Dr M. Paul Dr S. Sukumaran Dr Y. Kim | | | | | | | | | | | | | | | | | | | | |
| **REFERRAL DETAILS** | | | | | | | | | | | | | | | | | | | | |
| **Referral Date:** | | | | | | **Date of Injury:**  **Eligible & ready:** | | | | | | | | | | |  | | | |
| **Referring Hospital:** | | | | | | | | | | | | **Ward:** | | | | | | | | |
| **Referrer’s Name:** | | | | | | | | | | | | **Phone Number:** | | | | | | | | |
| **Referring Doctor:** | | | | | | | | | | | |  | | | | | | | | |
| **Mo Provider No:** | | | | | | | | | | | | **Signed:** | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | | | |
| **Family Name:** | | | | | | | | | **Given Name/s:** | | | | | | | | | | | |
| **D.O.B:** | | | | | | | | | **Gender:** Male Female | | | | | | | | | | | |
| **Contact Number:** | | | | | | | | | | | | | | | | | | | | |
| **Interpreter Required:** Yes  No | | | | | | | | | **Interpreter Language Required:** | | | | | | | | | | | |
| **Next of Kin:** | | | | **Relationship:** | | | | | | | | | | **Contact Number:** | | | | | | |
| **Next of Kin:** | | | | **Relationship:** | | | | | | | | | | **Contact Number:** | | | | | | |
| **INJURY & CURRENT HEALTH STATUS** | | | | | | | | | | | | | | | | | | | | |
| **Cause of Injury / Other Injuries Sustained / Synopsis of Admission:** | | | | | | | | | | | | | | | | | | | | |
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| **Investigations & Results:** | | | | | | | | | | | | | | | | | | | | |
| **Loss of Consciousness** Yes Duration: No | | | | | | | | | | | | | | | | **Initial GCS:** | | | | |
| **Post Traumatic Amnesia (PTA)** Yes No N/A  If out of PTA, period of PTA: Dates: No. of days:  If still in PTA, state last 3 days of Westmead PTA Scale Score: | | | | | | | | | | | | | | | | | | | | |
| **Seizures:** Yes No If yes, please provide details: | | | | | | | | | | | | | | | | | | | | |
| **Infectious Status:** | | | | | | | | | | | | | | | | | | | | |
| **Medical History:** | | | | | | | | | | | | | | | | | | | | |
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| **CURRENT FUNCTIONAL LEVEL & CARE NEEDS** | | | | | | | | | | | | | | | | | | | | |
| **Current Behavioural Issues:** Yes No | | | | | | | | | | | | | | | | | | | | |
| If yes, please specify: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Mobility & Transfers:** Independent Supervised Requires Assistance | | | | | | | | | | | | | | | | | | | | |
| **Respiratory:** Oxygen  Yes  No Tracheostomy  Yes  No Date of Decannulation: | | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | | |
| **Personal ADL:**  Independent Supervised Requires Assistance | | | | | | | | | | | | | | | | | | | Continent: Yes No | |
| **Diet:** | **Diet:** Regular Easy to chew Soft & bite-sized Minced & moist  Pureed  Dysphagic- customised PEG/NET  **Fluid:** Thin Mildly Thick Moderately Thick Extremely Thick  Reason for modified diet/fluids: | | | | | | | | | | | | | | | | | | | |
| **Cognition:** Intact Impaired **MOCA**  Yes Score: /30 No | | | | | | | | | | | | | | | | | | | | |
| Please specify any deficits: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Communication** Intact Impaired | | | | | | | | | | | | | | | | | | | | |
| Comprehension: Please specify any deficits | | | | | | | | Expression: Please specify any deficits | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | |
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| **Skin Integrity:** | | | | | | | | | | | | | | | | | | | | |
| **SOCIAL PROFILE** | | | | | | | | | | | | | | | | | | | | |
| **Lives with** | | Alone Spouse / Partner Children Parents Friends Other | | | | | | | | | | | | | | | | | | |
| **Accommodation** | | Home Unit Other **Comments:** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **South Australian Civil and Administrative Tribunal (SACAT) orders:** Yes No | | | | | | | | | | | | | | | | | | | | |
| Guardianship | | | Administration | | | | | | | | Section 32 | | | | | | | | | Public Trustee |
| **Employment:** Employed Unemployed Not in Labour Force Student Retired (for Age) | | | | | | | | | | | | | | | | | | | | |
| **Nature of Premorbid Work or Study** (where applicable): | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **PREVIOUS FUNCTIONAL STATUS** | | | | | | | | | | | | | | | | | | | | |
| **Personal ADL:** Independent Supervised Requires Assistance | | | | | | | | | | | | | | | | | | **Continent:** Yes No | | |
| **Domestic ADL:** Independent Supervised Requires Assistance | | | | | | | | | | | | | | | | | | | | |
| **Community ADL:** Independent Supervised Requires Assistance | | | | | | | | | | | | | | | | | | | | |
| **Driving:** Yes No | | | | | | | | | |  | | | | | | | | | | |
| **INPATIENT REFERRAL ONLY** | | | | | | | | | | | | | | | | | | | | |
| **Reason for Rehabilitation (i.e. active, community care planning, assessment / evaluation):** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Rehabilitation Goals:** | | | | | | | | | | | | | | | | | | | | |
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| **CONCUSSION & MILD TBI ONLY: INFORMATION & ADVICE** | | | | | | | | | | | | | | | | | | | | |
| **Head Injury Information handout provided to patient:** | | | | | | | | | | | | | Yes  No | | | | | | | |
| **Additional recommendations / precautions:** | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | **Signature:** | | | | | | | | | | **Date:** | | | | | |
| **Estimated LOS / Discharge Date:** | | | | | | | **Discharge Destination:** | | | | | | | | | | | | | |

***Please send completed form to BIRU CPC email to Health.Birunurseconsultantreferrals@sa.gov.au***

***Phone 0403 149 302***