Government of South Australia
SA Health

Central Adelaide Rehabilitation Service

SA SPINAL CORD INJURY SERVICE (SASCIS)
IN-PATIENT PROGRAMME REFERRAL FORM
Email to Health.CALHNRehabService@sa.gov.au

Please refer to SASCIS admission criteria to ensure that referral is appropriate

Name **Address** **DOB** **RAH URN**		Sex: ☐ **M** ☐ **F** **MR No** (if not from RAH):	
Hospital:	Unit/Ward:	Acute Admission Date:	
Next of Kin:		Consultant:	Contact No:
Patient informed of referral: ☐ **Y** ☐ **N**		**Has prognosis been discussed?** ☐ **Y** ☐ **N**	

SITUATION

☐ **Traumatic SCI** ☐ **Non Traumatic SCI**	AIS level & classification:
ISNCSCI form attached: ☐ **Y** ☐ **N** Please go to website: www.isncscialgorithm.com to download ISNCSCI form	
Cause of Injury (e.g. MVA/fall/assault) or NTSCI diagnosis:	
Fracture level:	Date of injury/onset:
Type of surgical fixation:	Date:
☐ **Collars or braces required** – describe type of collar / brace and duration required:	
☐ **Ventilation required**	☐ **Tracheostomy** – reason:

Other injuries and management

☐ **Head Injuries** – describe: ☐ PTA testing done if concurrent traumatic brain injury	☐ **Long bony injuries** – describe:
☐ **Wounds** – describe:	☐ **Internal injuries** – describe:
☐ **Other** – describe:	Weight bearing restrictions and duration:

BACKGROUND

Brief history of current admission:
Medical history and comorbidities:

ASSESSMENT

CONTINENCE		
☐ **Urinary voiding dysfunction** – describe:		☐ **Catheter** – describe:
☐ **Bowel dysfunction** – describe:		
SKIN INTEGRITY		
☐ **Intact**	☐ **Pressure injury** – describe site and grade:	
☐ **Surgical Wound** – describe:	☐ **Wound infection** – describe:	
☐ **Sutures/staples**	Date for suture staple removal:	
☐ **Dressings required** – type and frequency:		

MULTI RESISTANT ORGANISMS (MRO): ☐ **Y** ☐ **N**	Type of MRO:

DIET ☐Normal ☐ Soft ☐ Puree ☐ Other (describe):			
☐ **Significant weight loss** – describe:		☐ **PEG**	☐ **NGT**
Weight (kg):	Height (cm):	BMI:	
☐ **Diabetes**	☐ **Insulin dependent** – describe:		

MOBILITY – Falls risk?: ☐ **Y** ☐ **N**	
a.) Bed mobility:	
b.) Transfers:	
c.) Gait:	
d.) Weight bearing limitation to upper or lower limbs: ☐ **Y** ☐ **N**	
Describe location and duration of limitations:	
e.) Sitting out of bed: ☐ **Y** ☐ **N**	
Tolerance (duration – minutes):	
Describe the chair and cushion:	
UPPER LIMB FUNCTION - Affected?: ☐ **Y** ☐ **N**	
Describe upper limb function:	
COMMUNICATION/COGNITIVE FUNCTION	
Patient able to understand instructions? ☐ **Y** ☐ **N** Express self effectively? ☐ **Y** ☐ **N**	
Any behavioural problems demonstrated? ☐ **Y** ☐ **N**	
Describe behavioural problems:	
Alcohol or drug use: ☐ **Y** ☐ **N**	Patient full oriented: ☐ **Y** ☐ **N**
Memory intact: ☐ **Y** ☐ **N** – if no, MoCA or MMSE score:	
Preferred languages: ☐ English ☐ Other (specify): ☐ Interpreter required (language):	

RECOMMENDATION:

☐ **Early notification**	☐ **Consult only**	☐ **Consideration for admission**
Briefly describe patient's understanding/expectations/goals regarding potential admission to SASCIS:		
DISCHARGE PLAN		
Planned discharge destination following rehabilitation: ☐ Home ☐ Other		
If "other" please describe:		
Was the patient previously living alone? ☐ **Y** ☐ **N**		
Any further information re discharge destination:		
Does the patient require alternative accommodation? ☐ **Y** ☐ **N**		
If "yes" have applications been submitted (e.g.: residential care, Community Housing Register, private organisation)?: ☐ **Y** ☐ **N**		
Organisation:	Date of application:	
Organisation:	Date of application:	
Patient receiving support from outside agencies: ☐ **Y** ☐ **N**		
If "yes" please give details:		
NDIS referral commenced: ☐ **Y** ☐ **N** ☐ **N/A**	Referral date:	
Has the patient had any social work involvement?: ☐ **Y** ☐ **N**		
Name of social worker:	Reason of involvement:	

REFERRER DETAILS

Name (please print):	Designation:	Signature:
Date of referral:	Phone/Pager No:	
Planned follow up by referring clinic (e.g. OPD review, follow up imaging):		
Date:	Clinic:	

If you would like to discuss this referral before sending it, please call the SASCIS medical officer on (08) 7326 1940

Email completed Form to Central Adelaide Rehabilitation Services – Patient Flow Coordinator