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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:** |
|  |
|  |
|  |
| **Investigations & Results:**  |
| **Loss of Consciousness** [ ] Yes Duration: [ ] No | **Initial GCS:** |
| **Post Traumatic Amnesia (PTA)** [ ] Yes [ ] No [ ] N/AIf 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:** |
|  |
| **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 |
|  |  |
|  |  |
| **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:**  |
|  |
| **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***