South Australian Brain Injury Rehabilitation Services (SA BIRS)

**Please Fax all referrals to BIRCH**

**Fax: 8222 1871**

**Enquiries to BIRCH Referrals Officer**

**Tel: 8222 1888**

Brain Injury Rehabilitation Community & Home (BIRCH)

NAMED DOCTOR REFERRAL FORM

***Please respond to each question, providing as much detail as possible. This information***

***forms the basis for prioritisation and decisions regarding referrals.***

PATIENT LABEL

Unit Record No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Given names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_

**A. CLIENT INFORMATION**

1. Name

Age:     DOB:    /    /      Sex:

RAH UR:       Other UR:

2. Residential Address :

Postal Address *(if different)* :

3. Client Phone (H)       (M)

4. Emergency Contact Name       Relationship to client

5. Emergency Contact Phone (H)       (M)

6. Is the client currently in an inpatient facility? Yes No Date of Discharge   /    /

7. Interpreter needed? Yes  No  Language

8. Does client have transport to attend therapy sessions? Yes  No

9. Can client independently and safely transfer and manage their toileting? Yes  No

10. Compensable: Yes  No  If yes tick - Allianz  - LSA  - Return to Work SA  - Other

11. Local Doctor / GP:       GP Phone

12. GP Practice Address

**B. CLINICAL**

1. Date of Injury    /    /      2. Main diagnosis (include cause and details of brain injury)

3. Medical history (including all major illnesses, injuries, allergies, psychiatric history or recent

substance abuse)

4. Details of planned surgery / treatment

5. Current medications:

6. Neuropsychological Assessment Completed? Yes  No  Unsure

Date performed    /    /

BIRCH REFERRAL FORM - **Client Name**       RAH UR:

**C. IMPACT OF ACQUIRED BRAIN INJURY ON INDIVIDUAL *Please do not leave any questions in Section C blank, either complete or indicate nil Issues or unknown as appropriate***

1. Cognitive:

2. Physical:

3. Communication:

4. Visual / Perceptual:

5. Emotional / Behavioural / Social

6. Activities of daily living

7. Occupation or Study:       Current Status / Situation:

**D. LIVING ARRANGEMENTS**

1. Prior to acquired brain injury was the person living alone: Yes  No

2. Current / intended community living arrangements: Alone  With others

3. Who lives in the house (include ages of any children)

4. What support is the client currently receiving?

5. Are there any planned changes to living arrangements (e.g.: moving from supported)

accommodation to living alone

**E. CLIENT’S REHABILITATION GOALS**



**F. PERSON REFERRING**

1. Name       Provider Number

2. Signature Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Phone       Fax       Date of referral    /    /

4. Contact details of any other agencies and therapists currently involved?

Name       Phone

Name       Phone

BIRCH REFERRAL FORM - **Client Name**       RAH UR:

Client is aware of and consents to the referral? Yes  No

Has the client been referred to another rehabilitation service? Yes  No

Which service(s)?

**Referral to Dr Maria Paul/Dr Kim Yong**

**Referral to Registrar**

Was home visit completed while inpatient? Yes  No

If so, any issues for safety of BIRCH staff visiting client at home?

**Additional Information Attached**

**Please fax completed form and additional information**

**(including latest discharge summaries) to BIRCH on 8222 1871**