Health Northern NSW Local Health District NSW Spinal Outreach Service & Rural Spinal Cord Injury Service	Family Name:	MRN:
	Given Name:	□ Male □ Female
	D.O.B: / /	
FACILITY:	Address:	
	Location/ward	
	Complete details or affix patient label here	

REFERRAL FORM

CLIENT DETAILS

Client Name:		DOB:
Address:		
Suburb/Town:		Post Code:
PHONE (H):	(M):	(W):
E-Mail Address: (if applicable)		
NOK:		NOK Contact Number:

INJURY DETAILS

Level of Injury:	Cause of Injury:
Date of Injury:	Place where Injury Occurred:
Facility of Acute treatment (eg. where the client was first admitted post injury):	
Is the client eligible for the RSCIS as defined by the SSCIS criteria? Yes ☐ No ☐ (if not why not)	

Is the client a:

☐ Transitional (Newly Acquired) Injury Client ☐ Readmission (Readmitted to Spinal Unit or to a local hospital)

☐ Referral from SOS post Rural Clinic? ☐ Community based client

Is referral a notification: Yes ☐ No ☐	Is referral a direct referral: Yes ☐ No ☐
Has the client previously been a notification and has become an active referral?	Yes ☐ No ☐

REFERRER DETAILS

Date of referral:	
Name of referring organisation:	
Name of referring Clinician / other staff member:	
Address:	
Contact Number:	Contact Email:

GENERAL PRACTITIONER DETAILS		
First Name:	Surname:	
Address:		
Phone	Email:	Fax:

SOURCE OF REFERRAL

☐ **Spinal Unit**
- ☐ Moorong
- ☐ RNSH
- ☐ POWH
- ☐ Other (eg Qld,Vic)

☐ **Spinal Outreach Service**
- ☐ Post clinic
- ☐ Other

☐ **SSCIS Seating Service**
- ☐ Northern
- ☐ Southern

- ☐ Local Rehabilitation Specialist
- ☐ Local General Practitioner
- ☐ Local Community Nurse
- ☐ Local Physiotherapist
- ☐ Local Occupational Therapist
- ☐ Wound Consultant
- ☐ Continence Consultant
- ☐ Case Manager (eg. Community Options)
- ☐ Care Provider (eg. Home Care)
- ☐ Counsellor
- ☐ Lifetime Care Scheme
- ☐ Local social worker
- ☐ Local rural hospital/clinician
- ☐ Other

Is the client aware of the referral: ☐ Yes ☐ No

Has the client consented to the RSCIS? ☐ Yes ☐ No

Does the client have goals to be pursued? ☐ Yes ☐ No (if no consider appropriateness of referral)

Reason for referral as stated by referrer: (eg. requires equipment review and linking to local OT)

_____
_____
_____
_____

Any relevant presenting history:

_____
_____
_____
_____

Please tick the **main** reasons for referral:

- Continence Management ☐
  - ☐ Bowels
  - ☐ Bladder
- Pain Management ☐
- Spasm Management ☐
- Skin Management (preventative) ☐
- Pressure Ulcer management (current) ☐
- Autonomic Dysreflexia ☐
- Seating ☐
- Equipment Review ☐
- Care Provider Issues ☐
- Home Modifications ☐
- Mental Health (eg. Depression) ☐
- Carer Support ☐
- Transport Issues ☐
- Community Access issues
- Shoulder review ☐
- Other ☐

Referral Accepted: ☐ Yes ☐ No

If no, please explain reasoning for declining referral (eg client does not fit SSCIS criteria)

_____

Anticipated response time required as stated by referrer (eg. within the next two weeks)

_____

Response Time anticipated by RSCIS Coordinator :(eg within next month/next planned trip to that area, dependant on wait list)

_____

Actions directly following referral:

(1) Phone contact to client to make appointment for home visit ☐ Date .....

(2) Phone contact to client to attend initial assessment over the phone (if geographically not feasible to do home visit within anticipated time frame) ☐ Date .....

(3) Provide follow up to referrer following client contact ☐ Date .....

(4)Keep client details on file/database for future reference (notifications) ☐

(5) Send referral/notification details to SOS when consent processes in place ☐ Date .....

(6) Add client to waiting list ☐ Date .....

(7) Refer client to SOS clinic (contact SOS to inform) ☐ Date .....

Date of commencement of episode: _____/_____/_____

Anticipated Discharge Date: _____/_____/_____