Government of South Australia
SA Health

Central Adelaide Rehabilitation Service
Hampstead Rehabilitation Centre

SA SPINAL CORD INJURY SERVICE (SASCIS)
IN-PATIENT PROGRAMME REFERRAL FORM
Fax No. 08 8222 1464

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

Name **Address** **DOB** **RAH URN**	**PLACE PATIENT STICKER HERE**	Sex: ☐ **M** ☐ **F** MR No (if not from RAH):
Hospital:	Unit/Ward:	
Next of kin:	Consultant: Contact no:	
Patient informed of referral: ☐ Y ☐ N	**Has prognosis been discussed? (circle): ☐ Y ☐ N**	

SITUATION

☐ **Traumatic SCI** ☐ **Non Traumatic SCI**	AIS level & classification:
Cause of injury (eg 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 voiding 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** – type/dose:		

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 orientated: ☐ **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 (eg: residential care, Housing SA, 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:		
DSA referral commenced: ☐ **Y** ☐ **N**	Referral date:	
Has the patient had any social work involvement?: ☐ **Y** ☐ **N**		
Name of social worker:	Reason for involvement:	

REFERRER DETAILS

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

If you would like to discuss this referral before sending it, please call the SASCIS medical office on (08) 8222-1630