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| --- |
|  |
| **Referral To** |
| **Name** |       | *For details please refer to Contact Sheet* |
| **Fax** |       |
| **Email** |       |
| **Date of referral** |       |  |
|  |  |  |
| **Patient Details** |
| **Surname** |       | **First Name** |       |
| **MRN** |       | **Sex** |       |
| **DOB** |       | **Age** |       |
| **Address** |       |
|  | **Suburb** |       | **State** |       | **Postcode** |       |
| **Phone** | **Mobile** |       | **Home** |       | **Work** |       |
| **Medicare Number** |       | **Expiry Date** |       |  |  |
| **Country of Birth** |       | **Aboriginal/ Torres Strait Islander** |       |
| **Interpreter Needed** |       | **Language Spoken at Home** |       |
| **Parent/Guardian Information** |
| **Mother** | **Name** |       | **Phone** |       |
| **Father** | **Name** |       | **Phone** |       |
| **Other** | **Name** |       | **Phone** |       |
| **Next of Kin** |
| **Name** |       | **Relationship** |       |
| **Home Phone** |       | **Mobile Phone** |       |
| **Address** |       |  |  |
| **GP/Specialists** |  |  |  |
| **GP** | **Name** |       | **Phone** |       |
| **Specialist 1** | **Name** |       | **Phone** |       |
| **Specialist 1** | **Name** |       | **Phone** |       |
|  |
| **Referral Information** |
| **Referral Source** | **Name** |       | **Organisation** |       |
|  | **Phone** |       | **Fax** |       |
|  | **Email** |       | **Alternate Contact** |       |
| **Has referral been discussed with the family?** | **[ ] Yes** **[ ] No** | **Comments** |       |
| **Is the patient ready for rehab?** |       |
| **Reason For Referral**(must be completed to be accepted) |       |
| **Current Priorities /Family/Client Goals** |       |
|  |
| **Injury/Medical Information** |
| **Date of Injury** |       | **Injury Type** | **[ ] ABI** **[ ] TBI** |
| **Details of Injury/Diagnosis**(please state clearly the cause of injury) |       |
| **Length of PTA** |       | **Lowest GCS Score** |       |
| **Other Medical History** |       |
| **Place of Acute Care** |       |
| **Place of Inpatient Rehabilitation** |       |
|  |
| **Current Status** |
| **Current Function**Cognitive/Communication/ Physical/Behavioural/Social etc |       |
| **Current Medications** |       |
|  |
| **Social Environment** |
| **Family –** parents, siblings, extended family, pets |       |
| **Hobbies/Interests/Sports/ Favourite Things** |       |
| **Accommodation** |
| **Current Accommodation** – i.e. Private/Rental/DOH/Nil |       |
| **Access to house –** layout/stairs etc. |       |
| **School/TAFE** |
| **Name** |       |
| **Contact** |       |
| **Address** |       |
| **Teacher / Learning Support Officer** | **Name** |       |
| **Phone** |       |
| **Email** |       |
| **Principal** | **Name** |       |
| **Phone** |       |
| **Email** |       |
| **Current School Grade** |       |
| **School Performance Prior to Injury** |       |
| **Current School Performance** |       |
| **Employment** |
| **Employment Details** |       |
|  |
| **Insurer Information** |
| **Insurance Type** | **[ ] LTCS** **[ ] CTP/MAA** **[ ] Other** |       |
| **Insurer** | **Name** |       |
| **Address** |       |
| **Claim Number** |       |
| **Contact Person** | **Name** |       |
|  | **Phone** |       |
|  | **Email** |       |
| **Status** |       |
| **Solicitor** | **Name** |       |
| **Phone** |       |
| **Email** |       |
|  |
| **Services/Agencies Involved** |
| **Name** | **Phone** | **Email** | **Comments** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |
| **Risk Screen (cross as appropriate)** |
| History of aggression/violence/inappropriate behaviors | **[ ]**  |
| Risk of self-harm | **[ ]**  |
| Known substance use (inc tobacco) | **[ ]**  |
| Domestic Safety Issues | **[ ]**  |
| Presence of other persons who may pose a risk | **[ ]**  |
| Dangerous animals on premises | **[ ]**  |
| Environmental/Access risk – entry, lighting, personal hygiene | **[ ]**  |
| Firearms on the premises | **[ ]**  |
| Other | **[ ]**  |
| Comments |       |