BRAIN INJURY REHABILITATION UNIT – INPATIENT REFERRAL FORM
LIVERPOOL HOSPITAL

Liverpool Hospital Locked Bag 7103, Liverpool BC, NSW, 1871.
Reception: 02 8738 5495 All referrals to be sent to SWSLHD-LiverpoolBIRU@health.nsw.gov.au
Website: http://www.sswahs.nsw.gov.au/liverpool/biru

Please Note: Processing of this referral may be delayed until a Doctor from the referring Hospital/Ward/Practice has discussed it with the Doctor at Liverpool BIRU

REFERRAL DETAILS	**Referral Taken by:**		**Date of Referral:**
Brain Injury Unit Registrar or Specialist Contacted: No ☐ Yes ☐ **Name:** **Date:**			**Reason for Referral:** **Rehabilitation** ☐ **Assessment** ☐ **Other** ☐ **Comments:**
Name of Referrer:	**Dept/Position:**		**Contact Phone:**	**Fax:** **e-mail:**
Location/Hospital of Patient:	**Ward:**	**AMO:**	**Ward Phone:**	**S/B Rehabilitation Team:** **Yes** ☐ **No** ☐ **Name:**

PATIENT DETAILS	**MRN:**		**Medicare Number:**	
Name:	**Sex:**	**DOB:**	**Age:**	**Marital Status:**
Address:		**Phone:**		
Country of Birth:				

Australian Residential Status		**Indigenous Status**		**Vocational Status**
Australian Citizen	☐	**Aboriginal**	☐	**Employed: Yes** ☐ **No** ☐
Permanent Resident	☐	**Torres Strait Islander**	☐	**Description:**
Temporary Resident	☐	**Both**	☐	
Visitor	☐	**None**	☐	**Student: Yes** ☐ **No** ☐
Other	☐	**Not Known**	☐	**Description:**
Please Specify:				

Interpreter Needed: **Yes** ☐ **No** ☐	**Language (NESB):**
Patient notified of this referral: Yes ☐ **No** ☐ **NA** ☐	**Patient agrees to this referral: Yes** ☐ **No** ☐ **NA** ☐

NEXT OF KIN / CONTACT PERSON DETAILS

NOK/Contact Person:	**Relationship:**	**NOK Notified of this Referral: Yes** ☐ **No** ☐ **NA** ☐ **AGREES TO THIS REFERRAL Yes** ☐ **No** ☐ **Comments:**

Address:	**Phone:**	**Alternative Phone:**	**Mobile:**
Interpreter Needed: **Yes** ☐ **No** ☐	**Language (NESB):**		

INJURY DETAILS

Cause of Brain Injury:			**Date of Injury:**
MVA	☐	**If MVA specify whether patient was a**	**Type of Injury**
Assault	☐	**Driver** ☐	**Closed** ☐
Fall (other than sport)	☐	**Passenger** ☐	**Open** ☐
Impact of Object (other than assault)	☐	**Motorcyclist** ☐	**Open with Neurosurgery** ☐
Sport Injury	☐	**Cyclist** ☐	**Hypoxic** ☐
Gunshot/Penetrating Injury	☐	**Pedestrian** ☐	**Other** ☐
Stroke (Bleed/Infarct)	☐	**Pillion rider** ☐	**Please specify:**
Cardio/Respiratory failure	☐	**Other (fallen from)** ☐	
Other ABI (Hanging/OD/CO/etc)	☐	**Details:**	
Please specify:			

Compensable: Work Related Yes ☐ **No** ☐ **CTP Yes** ☐ **No** ☐ **LTCS Yes** ☐ **No** ☐ **Not Known** ☐

GCS at Scene (if known): **GCS on arrival at Acute Hospital:** **Not Known** ☐
From Ambulance report: Yes ☐ **No** ☐

Loss of Consciousness (LOC): Yes ☐ No ☐ Not Known ☐	**Period of LOC:**

Cerebral Imaging : Yes ☐ No ☐	**Cerebral Image findings:**
Neurosurgery: Yes ☐ No ☐	**Dates & Operation/s:**

CURRENT STATUS

Post Traumatic Amnesia (PTA): Currently in PTA Yes ☐ No ☐ Not known/NA ☐
Emerged from PTA on: Duration of PTA: days

Tracheostomy: No ☐ Yes ☐ Date In: Date Out:	**On oxygen: Yes ☐ No: ☐**
PEG: No ☐ Yes ☐ Date In: Date Out:	**If yes reason:**

Neurological Deficits:

Concurrent Medical or Surgical Diagnoses/Injuries:

Past Medical & Surgical History: (Include any Psychiatric or Drug & Alcohol history)

Social History: (Include social supports and CURRENT ACCOMMODATION for return after rehab if suitable)

GCS at Referral to BIRU Score:

Eye Opening:			Verbal Response:			Motor Response:		
Spontaneous	4	☐	Orientated	5	☐	Obey commands	6	☐
To Speech	3	☐	Confused	4	☐	Localises	5	☐
To Pain	2	☐	Inappropriate	3	☐	Withdraws	4	☐
Nil	1	☐	Incomprehensible	2	☐	Abnormal flexion	3	☐
			Nil	1	☐	Extensor Response	2	☐
						Nil	1	☐

Behavioural Problems:		Nutrition:		Mobility:	
Nil	☐	Normal	☐	Not walking	☐
Wanders	☐	Modified	☐	Can Stand - no assistance	☐
Agitated/Irritable	☐	NG feeds	☐	- with assistance	☐
Aggressive verb/physical	☐	PEG feeds	☐	Wheelchair mobile	☐
Requires restraint	☐	Details relevant:			
Requires one to one special	☐				

Bladder:		Bowel:			
Continent	☐	Continent	☐	Weight Bearing - None	☐
Incontinent	☐	Incontinent	☐	- Partial	☐
IDC/SPC	☐ Date In:			- As Tolerated	☐
Uridom	☐			- Full	☐
				Can walk - without assistance	☐
				- with assistance	☐
				- independently	☐

Wound/Infection:				Pressure Areas:		Any assistive device:
Nil	☐	VRE	☐	No	☐	Comments:
Yes	☐	MRAB	☐	Yes	☐	
MRSA	☐	IV Anti B	☐	Sites:		

Ready for Rehab Admission now: Yes ☐ No ☐ When:
If not reason:

INTAKE TEAM REMARKS (To be completed by Liverpool BIU staff)
Information Requested/Awaiting:

Date:		**Rec: ☐ Date:**
Date:		**Rec: ☐ Date:**
Date:		**Rec: ☐ Date:**
Referral Outcome: Date:		**Priority:**