Queensland Government

Metro North Hospital and Health Service

BRIGHTON BRAIN INJURY SERVICE REFERRAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

This form is to be completed for all referrals to be considered for rehabilitation by Brighton Brain Injury Service.

Phone: 3631 7640 **Fax:** 3631 7642 **Email:** brightonbraininjuryservice@health.qld.gov.au

Date of referral: ..../........./......... Referral for *(please tick)*: ☐ Rehabilitation ☐ Community Pathway

Key contact person *(from referring facility)*: .... **Phone number:** ....

Medical Report ☐ Summary attached

Date and history of illness including GCS at scene and injury list:

Past medical history *(pre illness or injury)* **and allergies:**

Surgical and other management:

MRI / CT imaging reports:

Current GCS / level of arousal *(include appropriate measure CRS-R/similar)* **/ ongoing medical / surgical requirements:**

Medication *(including adverse reactions to medications- particular reference to medications that decrease level of arousal)*:

Ongoing management and investigations:

Appointments with referring facility:

Patient/family aware and has acknowledged the rehabilitation process at BBIS: ☐ Yes ☐ No

Comment:

Doctor name:	Phone:
Referring ward:	Hospital:

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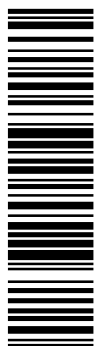

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Nursing Report

☐ Summary attached

Please tick box and add comments.

Respiratory: ☐ Tracheostomy ☐ Decannulated Date: ....../....../......

Hygiene: ☐ Shower chair ☐ Shower trolley ☐ Sponge
☐ Full assist ☐ Medium assist ☐ Minimum assist ☐ Independent

Comments:

Elimination: ☐ Incontinent ☐ Urine ☐ Faeces
☐ Continent ☐ IDC ☐ Bottle ☐ Urodome ☐ Independent

☐ Other: ....

Comments:

Behaviour risks identified & management strategies – *(Consider compliance, absconding, self harm or OVP risk restrictive practice measures (physical, mechanical, chemical)*:

☐ Level of supervision currently required and reasoning

Comment on behaviour issues, medications used, strategies employed and degree of success:

Infections status: ☐ VRE ☐ MRSA ☐ MRAB ☐ Other: ....

Skin integrity: Pressure area/wounds: ....

Current treatment:

Nurse's name: | Contact phone number:

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Occupational Therapy Report

☐ Summary attached

Functional status –
Premorbid *(including educational level, study and paid employment)*:

Current (PADL, IADL)

Current AT used / required / applications:

Home environment / barriers to discharge to previous accommodation:

Home visit completed: ☐ Yes ☐ No

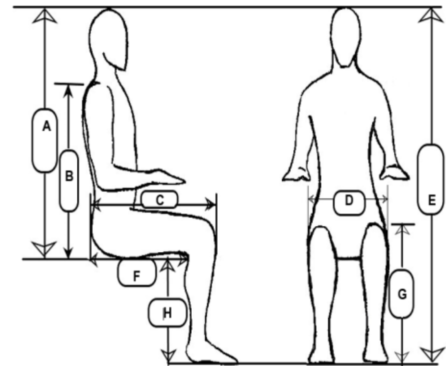
Impairments: Cognitive assessments completed: ☐ Yes ☐ No

Cognitive function *(attention / memory / executive function)*:

Length of PTA:

Sensory (vision / hearing / perception):

Upper limb function:



Wheelchair dimensions:

A:............ **B:**............ **C:**............ **D:**............

E:............ **F:**............ **G:**............ **H:**............

Current intervention / participation / perceived limitations:

Goals for OT intervention:

1.

2.

3.

4.

OT name:

Contact number:

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Speech Pathology Report ☐ Summary attached

Intubated: ☐ Yes ☐ No Period of intubation: .... to ....

Has tracheostomy: ☐ Yes ☐ No Type of tracheostomy / size: .... Date of decannulation: ...../...../.....

Level of arousal: ....

Swallowing:

Managing secretions: ☐ Yes ☐ No Strategies: ....

Oral trials started: ☐ Yes ☐ No ....

Swallow strategies: ....

Oral intake: ☐ Yes ☐ No Supplementation required: ☐ Yes ☐ No Type: ....

Diet: ....

Fluid: ....

Formal swallow assessment conducted: ☐ VFSS ☐ FEES ☐ Report(s) attached

Communication:

Speech: Functional ☐ Yes ☐ No **Language:** Functional ☐ Yes ☐ No

Trialled ACC: ☐ Yes ☐ No Comment: ....

Cognitive language deficits: : ☐ Yes ☐ No

Expression:

Comprehension:

Speech:

Swallow diagnosis:

Communication diagnosis:

Current intervention (frequency, duration):

Have they made any gains since admission: ☐ Yes ☐ No

Goals for intervention:

1.

2.

Comments:

Speech pathologist name: Contact number:

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Physiotherapy Report

☐ Summary attached

Previous level of function *(including mobility, social, ex-tolerance, physical requirements for work capacity)*:

Respiratory status:

Level or arousal *(formal measure if available)*:

Upper limb / lower limb assessment. Splints if applicable *(regime and skin integrity concerns)*:

Bed mobility and transfers:

Mobility and current equipment, falls risk:

Main problems *(movement, power, tone, posture, incoordination, orthopaedic)*:

Current interventions:

Current management plan and tolerance / participation *(no. sessions/day, length of sessions, seating schedule)*:

Current limitations and progress to date *(outcome measures if appropriate)*:

Barriers to discharge:

Goals:

1.

2.

3.

4.

Physiotherapist name:	Contact number:

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Clinical Psychology / Neuropsychology Report

Purpose of the referral:

Clinical Neuropsychology

- ☐ Cognitive Screening
- ☐ Assist with Diagnosis/Differential diagnosis
- ☐ Assess for emergence with a Minimally Conscious State
- ☐ Assess Cognitive Strengths and Weakness
- ☐ Cognitive Rehabilitation / Learning / Adaptive Compensatory Strategies

Clinical Psychology

- ☐ Review current mood e.g. depression or anxiety
- ☐ Concern emotional / social adjustment to injury
- ☐ Pain management
- ☐ Sleep management
- ☐ Positive behaviour support
- ☐ Caregiver coping and adjustment

Capacity Assessment

- ☐ Financial capacity assessment
- ☐ EPOA capacity assessment
- ☐ Capacity for lifestyle/accommodation decisions
- ☐ Other (please specify): ....

....

....

....

Presenting behaviour/s of concern:
Description (frequency/intensity/duration):

High risk behaviours *(for boxes checked please indicate if current or historical)*:

- ☐ Aggression or violence ....
- ☐ Self-harm ....
- ☐ Suicidal ideation / plan / intent ....
- ☐ Expressing intent to harm others ....
  Access to available means.
- ☐ Risk-taking/impulsivity ....
- ☐ Inappropriate sexual behaviour ....
- ☐ Absconding ....
- ☐ Substance use/abuse ....
- ☐ Any information about friends or relatives who may pose a risk

Restrictive practice measures: ☐ Physical ☐ Chemical ☐ Mechanical ☐ Environmental

Positive behaviour support strategies/plans: ☐ No ☐ Yes Date: ...../...../..... ☐ Attached

Mental status examination

Mood (reported): ....

Affect (emotional expression): ....

Sleep: ....

Appetite: ....

Arousal/energy: ....

Rapport (cooperative/compliant): ....

Perceptual abnormalities (delusions/hallucinations): ....

Cognitive state

Orientation – TPP: ....

Attention/concentration: ....

Short term memory: ....

Long term memory: ....

Executive functions: ....

Cognitive Screening / Assessment completed: ☐ No ☐ Yes Date: ...../...../..... ☐ Attached

Previous Neurological / Psychological / Psychiatric Report: ☐ No ☐ Yes Date: ...../...../..... ☐ Attached

Neuroimaging: ☐ CT ☐ MRI ☐ SPECT Date: ...../...../..... ☐ Attached

Past Psychiatric or Psychological history *(admissions; diagnoses, co-morbid conditions, treatment, compliance, barriers to treatment, longitudinal risk issues)*:

Goals:

1.

2.

3.

Referred by - Psychologist's name:	Contact number:

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Nutrition / Dietetics Report

☐ Summary attached

Estimated requirements *(energy, protein, fluid, other)*:

Current diet type *(e.g. HPHE, low K)*:

☐ Oral diet ☐ Tube feed Date inserted: ....../....../......

Diet texture	**Fluid thickness**	**Type of tube:**	**Insertion method:**
☐ Puree	☐ Thin	☐ Nasogastric	☐ Endoscopic
☐ Minced and moist	☐ Mildly thick	☐ Nasojejunal	☐ Radiological
☐ Soft	☐ Moderately thick	☐ Gastrostomy (PEG)	☐ Surgical
☐ Full	☐ Extremely thick	☐ PEG-Jejunal	☐ Other: ....
		☐ Surgical jejunostomy	

Type of PEG tube: ....

Formula name: ....

☐ Bolus (ml) ☐ Continuous (ml/hr): ....

Time of feeds: ....

Water flushes (ml): ....

Provided per 24-hour period: Total energy (kj): .... Protein (g): .... Fluid (ml): ....

Oral supplements and amount details:

Reason for nutrition referral:

Anthropometry:

Height (cm): .... Weight (kg): .... BMI: .... Goal weight (kg): ....

Weight history:

SGA or PGA SGA and date of assessment:

Relevant clinical data (including bloods and medications):

Summary of intervention and education/goals:

Dietitian's name: Contact number:

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Social Work Report ☐ Summary attached

Next of kin contact details:

Name: .... Contact number: ....

Name: .... Contact number: ....

Pre-morbid social information:

Education/employment:

Enduring Power of Attorney:	☐ Yes	☐ No	Detail: ....
Statutory Health Attorney:	☐ Yes	☐ No	Detail: ....
Advance Health Care Directive:	☐ Yes	☐ No	Detail: ....
QCAT Application lodged:	☐ Yes	☐ No	Detail: ....

Discharge planning:

NDIS / NIIS Q:	☐ Yes	☐ No	Detail: ....
Housing Application made:	☐ Yes	☐ No	Detail: ....
NOK advised of rehab referral:	☐ Yes	☐ No	Detail: ....

Next of kin understanding of prognosis / rehab / length of stay:

Carer: ☐ Partner ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Friends ☐ Other/s

Level of support networks:

☐ Good social supports ☐ Adequate social supports ☐ Perceives insufficient / inadequate supports

☐ Difficulties/significant issues relating to social supports / strained relationships

Additional comments:

Social Worker's name: Contact number:

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