

UR:

Add Label, or details below

Referral to Victorian Acquired Brain Injury (ABI) Rehabilitation Services (inpatient)

REFERRAL PROCESS

The Victorian ABI Rehabilitation Services at Alfred Health & Austin Health are state-wide services that provide rehabilitation for people with an Acquired Brain Injury. The two Victorian ABI Rehabilitation Services will work closely together to determine the most suitable service to assess the patient and the most suitable bed for the patient.

- Both services accept public patients. Caulfield Hospital also has services for severely injured compensable TAC/ VWA patients. Note: Only Caulfield Hospital can accept referrals for patients with tracheostomies.
- Both services accept referrals for patients with an ABI from traumatic and non traumatic causes (hypoxic, stroke, other non- progressive causes)
- This referral is to be used by health professionals to refer to the Victorian ABI Rehabilitation Services at Alfred Health (Caulfield Hospital) or Austin Health (Royal Talbot Rehabilitation Centre) only.
- For routine referrals to subacute rehabilitation please follow the subacute referral processes. If you are not sure where a patient is best referred contact your local subacute rehabilitation assessment service
- Referrers will be contacted within 1 business day of receipt of referral. More information may be sought to determine suitability of the patient and where further assessment of the patient is required by the ABI Rehabilitation Service this will occur within 3 business days to determine an outcome.

Attach photocopies of the following (if available):

- | | | |
|--|---|---|
| <input type="checkbox"/> Allied Health Assessments | <input type="checkbox"/> Relevant imaging and pathology | <input type="checkbox"/> Current medication and obs chart |
| <input type="checkbox"/> Psych, neuro psych notes | <input type="checkbox"/> Westmead WMPTAS | <input type="checkbox"/> Tracheostomy Suction Chart (if applicable) |

Service Referred to	Address	Return completed Referral to	Contact Number
<input type="checkbox"/> Alfred Health	Caulfield Hospital 260 Kooyong Road Caulfield VIC 3162	Fax: 03 9076 5013 abirehab@alfredhealth.org.au	Rehab and Aged Care Assessment Service Ph: 03 9076 6575 or 0419 770 095 https://www.alfredhealth.org.au/services/hp/acquire-d-brain-injury-rehabilitation/
<input type="checkbox"/> Austin Health	Royal Talbot Rehabilitation Centre 1 Yarra Boulevard Kew VIC 3101	Fax: 03 9490 7523	ABI Unit Ph: 03 9490 7622 Email: abi.unit@austin.org.au

REFERRAL DETAILS

Date of Referral	Referring Hospital	Ward
Referrers Name	Position	
Contact Number and Fax Number		

PATIENT DETAILS

Family Name	Given Name/s
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not known
Address	Post code
Phone No. Mobile & Home	Private Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare Number	Fund & Number
Permanent Australian Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	Referring Service UR No.
Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> No	Language/s Spoken
Person Responsible / Guardian Name	Interpreter Language Required
Relationship to Patient	Phone
GP Name	GP Phone Number
GP Address	GP Fax Number

INJURY & CURRENT HEALTH STATUS

Injury Date		Compensable	<input type="checkbox"/> Yes (TAC) <input type="checkbox"/> Yes (Vic WorkCover Authority) <input type="checkbox"/> No		
	TAC / WorkCover Claim Number				
Injury Cause	<input type="checkbox"/> Motor Vehicle / Motor Bike Accident <input type="checkbox"/> Pushbike Accident <input type="checkbox"/> Pedestrian <input type="checkbox"/> Assault <input type="checkbox"/> Industrial / Work <input type="checkbox"/> Fall <input type="checkbox"/> Other				
Brain Injury Type	<input type="checkbox"/> Stroke Ischaemic <input type="checkbox"/> Stroke Haemorrhagic <input type="checkbox"/> L sided <input type="checkbox"/> R sided <input type="checkbox"/> Other				
Brain Dysfunction	Non Traumatic <input type="checkbox"/> Sub-Arachnoid Haemorrhage <input type="checkbox"/> Anoxic Brain Damage <input type="checkbox"/> Other Non-Traumatic Brain Dysfunction				
	Traumatic <input type="checkbox"/> Open Injury <input type="checkbox"/> Closed Injury				
Other injuries (list)					
TBI ONLY: GCS - Glasgow Coma Scale	GCS on Admission		GCS at time of referral		
TBI ONLY: Loss of Consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes - Period of Loss of Consciousness		
Neurosurgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes – Date and Surgery Description:			
Tracheostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date In:		Date Out:	
Tracheostomy Criteria <i>(This section must be completed if patient has a tracheostomy)</i>	Pt requires <30% inspired O2	<input type="checkbox"/> Yes <input type="checkbox"/> No		Comments:	
	No assistance with ventilation in last 72 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Sats >95% last 24 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Requires <4hrs suctioning	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Cook tracheostomy with cannula in situ	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other Tracheostomy Management Issues / complications e.g. frequency of suctioning, sputum load, cuff deflation, failed or unplanned decannulation, tube obstruction/ displacement, wound breakdown, infection or bleeding, pneumothorax/ haemothorax If applicable attach suction chart					
TBI ONLY: Post-traumatic amnesia (PTA)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes – Out of PTA?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If out of PTA, period of PTA	Dates		Days		
If still in PTA, state last 3 days of Westmead PTA Scale Score	Date		Date	Date	
	Score		Score	Score	
Other Medical and / or Surgical Problems					

INJURY & CURRENT HEALTH STATUS cont....

<p>Psychiatric History / Current Psychiatric Issues</p> <p><i>If current psych issues attach psych plan and progress notes</i></p>	
<p>Relevant Medical History</p>	
<p>Drug / Alcohol / Smoking History</p>	
<p>History of Behavioural / Forensic Issues</p>	
<p>History of Seizure</p> <p><input type="checkbox"/> Yes, specify</p> <p><input type="checkbox"/> No</p>	
<p>Current Medications</p>	
<p>Investigations, Results and Treatment</p>	
<p>Allergies</p>	
<p>Issues Requiring Return to Acute Hospital <i>(Including Expected Timeframe for Any Planned Procedures)</i></p>	

PREMORBID FUNCTION & SOCIAL HISTORY

<p>Lives with</p>	<p><input type="checkbox"/> Alone <input type="checkbox"/> Spouse / Partner <input type="checkbox"/> Children <input type="checkbox"/> Parents <input type="checkbox"/> Friends</p>
<p>Accommodation</p>	<p><input type="checkbox"/> Private Residence <input type="checkbox"/> Boarding House <input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Supported Residential Service (eg, Community Group Home) <input type="checkbox"/> Transitional Living Unite</p> <p><input type="checkbox"/> Residential Low Level Care (Hostel) <input type="checkbox"/> Residential High Level Care (Nursing Home)</p> <p><input type="checkbox"/> Other</p>

PREMORBID FUNCTION & SOCIAL HISTORY cont

Premorbid Personal ADL Eating	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> Required Assistance		
Showing	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> Required Assistance		
Dressing	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> Required Assistance		
Toileting	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> Required Assistance	Continent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Premorbid Domestic ADL	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> Required Assistance	Comments	
Premorbid Community ADL	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> Required Assistance	Comments	
Driving	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Premorbid Mobility	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> 1 person assist	<input type="checkbox"/> 2 person assist	
Premorbid Mobility Aid	Specify				
Premorbid Cognition	<input type="checkbox"/> Intact		<input type="checkbox"/> Mild Impairment	<input type="checkbox"/> Moderate Impairment	
Highest Level of Education Obtained	<input type="checkbox"/> Secondary School not completed	<input type="checkbox"/> Year 12 or equivalent	<input type="checkbox"/> TAFE Certificate		
	<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor Degree	<input type="checkbox"/> Post Graduate		
Premorbid Occupation	<input type="checkbox"/> Employed	<input type="checkbox"/> Not in labour force	<input type="checkbox"/> Student		
	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired (for age)	<input type="checkbox"/> Retired (for disability)		
Nature of Premorbid Work or Study (if applicable)					
Pre-Existing Carer Status	<input type="checkbox"/> No carer & does not require	<input type="checkbox"/> No carer & requires one	<input type="checkbox"/> Carer not living in		
	<input type="checkbox"/> Carer living in (not co-dependant)	<input type="checkbox"/> Carer living in (Co-dependant)			
Were any services received in month prior to impairment (if living in private residence)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, specify	<input type="checkbox"/> Domestic Assistance	<input type="checkbox"/> Meals	<input type="checkbox"/> Social Support	<input type="checkbox"/> Nursing Care	<input type="checkbox"/> Personal Care
	<input type="checkbox"/> Provision of goods & equipment	<input type="checkbox"/> Allied Health Care	<input type="checkbox"/> Transport Services	<input type="checkbox"/> Care Management	

CURRENT FUNCTIONAL LEVEL & CARE NEEDS

Current Behavioural Issues	1 = Absent		3 = Present to a Moderate Degree	
	2 = Present to a Slight Degree		4 = Present to an Extreme Degree	
Short attention span, easy distractibility, inability to concentrate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Impulsive, impatient, low tolerance for pain or frustration	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Uncooperative, resistant to care, demanding	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Violent and or threatening violence toward people or property	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Explosive and/or unpredictable anger	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Pulling at tubes, restraints, etc.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Wandering from treatment areas	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Restlessness, pacing, excessive movement	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Self-abusiveness, physical and/or verbal	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Other				

CURRENT FUNCTIONAL LEVEL & CARE NEEDS Cont

Current Behaviour / Management Strategies									
Weight Bearing Restrictions		<input type="checkbox"/> Full Weight Bear <input type="checkbox"/> Partial Weight Bear <input type="checkbox"/> Non Weight Bear							
Walking		<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> 1 Person assist <input type="checkbox"/> 2 Person assist <input type="checkbox"/> Unable							
Aids (list)									
Upper Limb Paresis		<input type="checkbox"/> Right <input type="checkbox"/> Left		Lower Limb Paresis		<input type="checkbox"/> Right <input type="checkbox"/> Left Spatial Neglect <input type="checkbox"/> Yes <input type="checkbox"/> No			
Continence		Bladder		<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Uridome					
		Other							
		Bowel		<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Other					
Skin	Pressure Injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No		List Areas			Braden Score		
Infection	<input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> MBL <input type="checkbox"/> VISA <input type="checkbox"/> Other								
Nutrition & Swallowing	<input type="checkbox"/> Normal diet <input type="checkbox"/> Fluid only <input type="checkbox"/> Thickened <input type="checkbox"/> Nectar <input type="checkbox"/> Vitamised								
	<input type="checkbox"/> Nasogastric tube <input type="checkbox"/> PEG <input type="checkbox"/> Nil								
Personal ADL	Eating	<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Required Assistance							
	Showering	<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Required Assistance							
	Dressing	<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Required Assistance							
	Toileting	<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Required Assistance							
Communication									
Language Comprehension		List deficits			Language Expression		List deficits		
Hearing		<input type="checkbox"/> NAD <input type="checkbox"/> Hearing aid <input type="checkbox"/> Other							
Vision		<input type="checkbox"/> Reading glasses <input type="checkbox"/> Distance glasses <input type="checkbox"/> Other							
Impairments and Current Aids									
Other Progress / Outstanding Issues / Special Needs <i>(attach additional documents if required)</i>									
Expected Discharge Destination		<input type="checkbox"/> Home Independent <input type="checkbox"/> Alternative accommodation							
		<input type="checkbox"/> Home with Supports <input type="checkbox"/> High care needs <input type="checkbox"/> Not yet known							