### STATE HEAD INJURY UNIT

### CONCUSSION PATHWAY REFERRAL FORM

Ground Floor E Block, Sir Charles Gairdner Hospital

**Ph:** 08 6457 4488 **Fax:** 08 6457 4489 **Email:** shiu@health.wa.gov.au

Please note: Eligibility for service – 16-65years, concussion sustained within 12 months of referral, ongoing issues are primarily concussion related. The concussion program is a time limited service. GP involvement is required to support ongoing management. Persons with protracted alcohol or substance use are ineligible for this program.

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| --- | --- | --- | --- |
| **NAME:** | **DOB:** | **UMRN:** | |
| **ADDRESS:** | | | **POSTCODE:** |
| **POSTAL ADDRESS** (if different from above)**:** | | | |
| **PHONE:       EMAIL:** | | | |
| **CONTACT:**  **Patient** or  **NOK** | | | |
| **INTERPRETER NEEDED**  **Yes**  **No LANGUAGE:** | | | |
| **MARITAL STATUS:** Married  Partner  Divorced/Separated  Never married | | | |
| **ABORIGINAL OR TORRES STRAIGHT ISLANDER?**  **Yes**  **No** | | | |
| **DOES THE CLIENT HAVE A GUARDIAN OR ENDURING GUARDIAN WITH THE FUNCTION OF MEDICAL DECISION MAKING?**  **Yes**  **No**  If yes, please provide details: | | | |
| **DATE OF CONCUSSION:** | | | |
| **CAUSE OF CONCUSSION**: | | | |
| **PAST MEDICAL HISTORY** (including psychological and psychiatric history): | | | |
| **HOSPITAL / E.D. ADMISSION:**  **Yes**  **No Date:** | | | |
| **GP DETAILS** (Required)**:** | | | |
| **OTHER SERVICES INVOLVED** (private services, medical specialist): | | | |
| **SOCIAL SITUATION:**(include living arrangements, social supports, work, employment status, driving)    **Are there any medicolegal issues**  **Yes**  **No**  **ICWA:**  **Yes**  **No**  **Workers Compensation?**  **Yes**  **No**  If yes, please provide details:    **CLINICAL RISK FACTORS?**  **Yes**  **No** (if yes, please elaborate*)*  **Behavioural** (e.g.: aggression, self-harm/suicide attempts, disinhibition, impulsivity, psychosis, personality change)  **Forensic** (e.g.: criminal conviction/s, current charges pending, Violence Restraining Orders, Community Orders, domestic violence)  **Psychosocial** (e.g.: home environment including risks from other occupants)  **Alcohol/Substance Abuse\***  ***\*Please note: any clients with active (or recent significant) alcohol or substance abuse are not eligible for the SHIU Concussion Pathway.***  **Other**  **If ‘Yes’ to any of the above, please elaborate:** | | | |
| **CONCUSSION SYMPTOMS** (Brief summary of ongoing symptoms – attach any recent assessments):  **PHYSICAL (incl. vestibular, balance, exertional, cervicogenic):**  **EMOTIONAL / BEHAVIOURAL:**  **SLEEP / FATIGUE:**  **COGNITION:** | | | |
| **REASON FOR REFERRAL:** | | | |
| **IS THE CLIENT AWARE OF THIS REFERRAL?**  **Yes**  **No** (if no, please elaborate) | | | |
| **REFERRER:** | | | |
| **ORGANISATION:** | | | |
| **ADDRESS:** | | | |
| **PHONE:** | | | |

**OFFICE USE ONLY:** **Referral taken by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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