Government of Western Australia
North Metropolitan Health Service
Public Health and Clinical Excellence

**OFFICIAL SENSITIVE**

# 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.

| | | |
|---|---|---|
| **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**<br>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:** _____