

Referral to SOS Metro and Rural Spinal Cord Injury Service (RSCIS)

Address:	Surname:	
	Given Names:	
Landline Ph Number:	MRN:	DOB:
Mobile:	Medicare No: <input type="text"/>	

Country of Birth:	Interpreter Required: No <input type="checkbox"/> Yes <input type="checkbox"/>	Language:
Client Marital Status: Married <input type="checkbox"/>	Single <input type="checkbox"/>	De Facto <input type="checkbox"/> Unknown <input type="checkbox"/>
Is the client Aboriginal/Torres Strait Islander? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Next of Kin/Alternative Contact Name:	Relationship:	Phone Number:
Client's GP:	GP Phone No:	GP Fax No:
GP Address:		
SPINAL SPECIALIST PROVIDING FOLLOW UP (ESSENTIAL for SOS REFERRAL):		
Date of follow-up appointment with Spinal Specialist: ____ / ____ / ____		

REFERRAL			
METRO Referral <input type="checkbox"/>	RURAL* Notification ¹ <input type="checkbox"/>	OR	RURAL Referral ² <input type="checkbox"/>
Referral Date: ____ / ____ / ____	NEW INJURY <input type="checkbox"/>	*READMISSION (established) <input type="checkbox"/>	
*Must have multidisciplinary goals for SOS to follow up			
Treating Spinal Unit/s:	POWH <input type="checkbox"/>	RNSH <input type="checkbox"/>	RR <input type="checkbox"/> PAEDS <input type="checkbox"/>
FUNDING			
Public <input type="checkbox"/>	NDIS <input type="checkbox"/>	My Aged Care <input type="checkbox"/>	Compensable (provide details) <input type="checkbox"/>
iCare LTCs <input type="checkbox"/>	iCare Workers Care <input type="checkbox"/>	Other <input type="checkbox"/>	Claim #:
Contact Details: (NDIS Support Coordinator /Case Manager/Insurance Co-ordinator etc):			
Has Case Manager been notified of routine SOS involvement post discharge? YES <input type="checkbox"/> No <input type="checkbox"/>			
SCI INJURY			
LEVEL OF INJURY:	ASIA SCORE: <input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
DATE OF INJURY: ____ / ____ / ____	CAUSE OF INJURY:		
Reason for current admission to hospital:			
Estimated DC date: ____ / ____ / ____ (Please include SOS on Discharge Summary distribution list)			

*Refer to SOS Clinical Services Priorities Document for further referral criteria.

¹Notification refers to clients whose information will be entered on the rural database for transfer of their details to the rural coordinators and invitation to future rural clinics.

²Referral: refers to where the request is for active follow up by the rural coordinator. Indications for referral include red flags and deteriorating health status. Rural clients being discharged from spinal units are not routine referrals to the rural coordinators.

REASON FOR REFERRAL TO SOS/RSCIS:

NURSING (*Bladder, Bowel, Skin, Equipment, Sexuality*)

MEDICAL (*Pain, Spasm, AD, Other*)

PHYSIOTHERAPY (*Mobility, Respiratory, Equipment, Rec Therapy, Upper Limb*)

OCCUPATIONAL THERAPY (*Equipment, Accommodation, Home Mods, Vocation/Leisure, Driving, Community Access*)

SOCIAL WORK/PSYCHOLOGY (*Cognitive, Care, Accommodation, Relationships*) Please contact SW prior to D/C ☐

LIFE ASPIRATIONS (*work, family, hobbies, entertainment, study*)

Recommended SOS Discipline for Client Service Co-ordinator Allocation (*Metro Clients only*)? ☐ Nurse ☐ PT ☐ OT ☐ SW

Other Information – Please indicate which other services are/will be involved with client

☐ SPS/SPCC

☐ Community/Private Nursing

☐ Community/Private OT

☐ Community/Private PT

☐ Community Options

☐ ParaQuad

☐ SCIA

☐ InVoc

☐ Vocational Services

☐ Other

Details of any services/referrals above (*names, contact numbers, appointment dates etc*):

List any **RISKS** that there might be for SOS staff (i.e. 2 person visit, aggression etc):

CONSENT - MUST be completed by referee for SOS to accept referral

Rural Clients – I have discussed a referral to the Rural Spinal Cord Injury Service (RSCIS) and client has agreed to a) have name and details placed on the rural database for contact regarding future clinics in the local area and/or b) for contact by the local RSCIS coordinator ☐

Metro clients - I have discussed referral to SOS with client and client has given verbal consent to be followed up by SOS ☐

Referred By (Name and designation): _____

Submit Referral by: Fax (02) 8078 6688

OR

Email: sos@royalrehab.com.au