**NORTH WEST REGIONAL SPINAL INJURIES CENTRE - REFERRAL FORM (Part 1)**

EMAIL: soh-tr.spinal@nhs.net

**PLEASE ENSURE THAT THE CENTRE IS INFORMED BY TELEPHONE IF YOU FAX OR EMAIL A REFERRAL OUTSIDE OFFICE HOURS**

TEL: 01704 704345 5pm – 9am, weekends & BH

**Please arrange for all diagnostic imaging related to the spine to be transferred to S&O Trust PACS system immediately  
  
This form should only be used for referrals from organisations who are not English NHS Trusts**English NHS Trust referrals should be submitted by the National SCI Database: https://nww.mdsas.nhs.uk/Spinal/

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| DATE OF REFERRAL | | | | | | TIME OF REFERRAL | | | | | | | | |
| **PATIENT DETAILS** | | | | | | |  | | | | | | | |
| NAME | | | | | | AGE | | | |  | | GENDER | |  |
| NHS NO. | | | | | | HOME POSTCODE | | | | | | | | |
| **CURRENT LOCATION** | | | | | | | | | | | | | | |
| REFERRING HOSPITAL | | | WARD | DATE OF  ADMISSION | | | | CONSULTANT | | | | | CONTACT DETAILS | |
|  | | |  |  | | | |  | | | | |  | |
| **DETAILS OF INJURY** | | | | | | | | | | | | | | |
| DATE OF INJURY | | TIME SINCE INJURY | | | | | | | **RESPIRATORY STATUS**  MAINTAINING OWN AIRWAY  VENTILATED:  ET TUBE / TRACHEOSTOMY / MASK  PREVIOUSLY VENTED, NOW WEANED | | | | | |
| LEVEL OF INJURY | COMPLETE / INCOMPLETE | | | | ASIA | | | |
| CAUSE OF INJURY  TRAUMATIC / NON TRAUMATIC | | | | | | | | |
| **TREATMENT TO DATE / CRITICAL ISSUES – include details of any head injury** | | | | | | | | | | | | | | |
| SPINAL  HEAD INJURY  CVS  RESPIRATORY | | | | | | | | | | | ADVICE GIVEN (To be completed by NWRSIC staff) | | | |
| **ANY OTHER RELEVANT MEDICAL HISTORY** | | | | | | | | | | | | | | |

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| PATIENT NAME | | | | | | NHS NO. | | | |
| **OTHER RELEVANT INFORMATION** | | | YES | | NO | If YES, please give further information | | | |
| PSYCHIATRIC HISTORY | | |  | |  |  | | | |
| BEHAVIOURAL ISSUES | | |  | |  |  | | | |
| DRUG/ALCOHOL DEPENDANCY | | |  | |  |  | | | |
| RESIDENCY/IMMIGRATION ISSUES | | |  | |  |  | | | |
| PRESSURE ULCERS Grade 3 or 4 | | |  | |  |  | | | |
| MRSA POSITIVE | | |  | |  |  | | | |
| **PATIENT DEMOGRAPHICS** | | | | | | | | | |
| DATE OF BIRTH | |  | | | | | | OCCUPATION |  |
| HEIGHT |  | WEIGHT | |  | | | | CONTACT DETAILS | |
| ADDRESS  Post code | | | | | | | | GP | |
| **NEXT OF KIN DETAILS** | | | | | | | | | |
| NAME | | | | | | | RELATIONSHIP TO PATIENT | | |
| ADDRESS | | | | | | | Any issues of note | | |
| CONTACT DETAILS | | | | | | |
| ADDITIONAL INFORMATION | | | | | | | | | |
| VENTILATION INFORMATION | | | | | | | DATE COMMENCED VENTILATION | | |
|  | | | | | | | IF PREVIOUSLY VENTILATED BUT NOW WEANED –  DATE COMMENCED  DATE WEANED | | |
| REFERRED BY (Print name) | | | | | | |  | | |
| REFERRAL TAKEN BY (Print name) | | | | | | |  | | |

**FOR USE IN NWRSIC**

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| **PRE- ADMISSION REVIEW** | | | | | | |
| PATIENT FIT FOR TRANSFER | YES  NO | | If no, reason and projected date fit | | | |
| OUTREACH VISIT REQUIRED | YES  NO | | THIS REFERRAL MUST BE ESCALATED TO A CONSULTANT/CASE MANAGER BY 9.30am FOLLOWING DAY (including weekends) | | | |
| VENT/WEANING PLAN REQUIRED | | YES  NO | | IF YES, THIS REFERRAL MUST BE ESCALATED TO THE RESPIRATORY TEAM OR CONSULTANT ON CALL BY 9.30am FOLLOWING DAY | | |
| CONFIRMED NO OTHER SCIC TAKING LEAD FOR OUTREACH – written confirmation required if yes | | | | | YES | NO |

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