**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 AIRWAYVENTILATED: ET TUBE / TRACHEOSTOMY / MASKPREVIOUSLY 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** |
| SPINALHEAD INJURYCVSRESPIRATORY | 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 |
| ADDRESSPost 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  | YESNO | If no, reason and projected date fit |
| OUTREACH VISIT REQUIRED | YESNO | THIS REFERRAL MUST BE ESCALATED TO A CONSULTANT/CASE MANAGER BY 9.30am FOLLOWING DAY (including weekends) |
| VENT/WEANING PLAN REQUIRED | YESNO | 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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