Department of Health
GOVERNMENT OF WESTERN AUSTRALIA

REFERRAL FORM
STATE HEAD INJURY UNIT (SHIU)

Ground Floor E Block
Sir Charles Gairdner Hospital
Ph: 6457 4488 **Fax**: 6457 4489 **Email**: shiu@health.wa.gov.au

Sir Charles Gairdner Hospital

Please note: SHIU provides services for people aged 16-65 who have an acquired brain injury e.g. trauma, stroke, tumour, encephalopathy and infection. People with degenerative neurological conditions and neurological conditions associated with protracted alcohol or substance use are not eligible. Priority is given to recent and severe injury. Radiological evidence of injury is generally required.

NAME:	**DOB:**	**UMRN:**
ADDRESS:		**POSTCODE:**
PHONES:		
CONTACT: ☐**Patient** or ☐**Other - NAME and RELATIONSHIP:**		
PHONES:		
DATE OF ACQUIRED BRAIN INJURY (ABI):		
DIAGNOSIS: (include head CT/MRI findings):		
CAUSE OF ABI:		
LENGTH OF PTA:	**GCS ON ADMISSION:** /15	
PAST MEDICAL HISTORY:		
ACUTE ADMISSION HOSPITAL:	**Admit date:**	**D/c date:**
IN-PATIENT REHAB HOSPITAL:	**Admit date:**	**D/c date:**
REFERRED TO RITH? ☐**Yes** ☐**No**	**RITH D/c date:**	

OUT-PATIENT THERAPY? ☐**Yes** ☐**No** (Current and planned)	**LOCATION OF SERVICES** (Current and planned)	**DISCHARGE DATE** (Include anticipated dates)
☐**Occupational Therapy**		
☐**Physiotherapy**		
☐**Speech Therapy**		
☐**Psychology**		
☐**Social Work**		

OTHER SERVICES INVOLVED:

SOCIAL SITUATION: (include living arrangement, social supports and discharge (D/c) destination.)

WORK and DRIVING STATUS:

IMPAIRMENTS (please elaborate and attach assessments)

☐ **Insight:**

☐ **Cognitive:**

☐ **Physical:**

☐ **Communication:**

☐ **Behavioural:**

☐ **Sensory and perceptual:**

☐ **Psychological:**

☐ **Seizures:**

HOME VISIT RISK FACTORS? ☐ **Yes** ☐ **No** (if yes, please elaborate)

☐ **Aggression** ☐ **Inappropriate behavior** ☐ **Substance abuse** ☐ **Environmental** ☐ **Infection**

Comments:

REASON FOR REFERRAL:

ADDITIONAL INFORMATION:

PATIENT AWARE OF THIS REFERRAL? ☐ **Yes** ☐ **No** (if no, please elaborate)

REFERRER:	**POSITION:**
ORGANISATION:	
ADDRESS:	
PHONE:	**DATE OF REFERRAL:**

OFFICE USE ONLY: **Referral taken by:** _____ W:\Rehabilitation\SCG\SHIU\SHIUreferral form Last update 22/08/16