**Women's and Children's Health Network**

# CHILD AND ADOLESCENT BRAIN INJURY REHABILITATION SERVICE (CABIRS)

# REFERRAL FORM

PATIENT LABEL

UR Number: _____

Surname: _____

Given Name: _____

D.O.B.: _____ Sex: _____

## PATIENT CONTACT DETAILS

| | |
|---|---|
| Parent/guardian name: | Relationship to patient: |
| Phone (H): | Phone (M): |
| Language spoken at home: | Interpreter required: Yes ☐ No ☐ |

Consent to refer obtained from patient/parent/guardian: Yes ☐ No ☐
If no, please provide details:

## REFERRAL SOURCE

| | |
|---|---|
| Name: | Date of referral: |
| Organisation / Relationship: | |
| Phone / contact details: | Signature: |

## REFERRAL DETAILS

Reason for referral:

| | |
|---|---|
| Date of injury: | Mechanism of injury: |
| Loss of consciousness: Yes ☐ No ☐<br>If yes, duration: | Post traumatic amnesia (if known): Yes ☑ No ☐<br>If yes, duration: |
| Glasgow Coma Scale at scene (if known): | Seizures: Yes ☐ No ☐<br>If yes, please provide details: |

Was there a CT or MRI? Yes ☐ No ☐
If yes, please provide details:

Other injuries, relevant history, including any previous head injuries or relevant medical history, social history / background:

CHILD & ADOLESCENT BRAIN INJURY REHAB SERVICE MR*



**V4 Office use only.**

Date received ..... Date of Medical triage ..... Date of CABIRS triage .....