Government of Western Australia
North Metropolitan Health Service

OFFICIAL SENSITIVE

STATE HEAD INJURY UNIT
CONCUSSION PATHWAY REFERRAL FORM

Ground Floor E Block, Sir Charles Gairdner Hospital
Ph: 08 6457 4488 **Fax:** 08 6457 4489 **Email:** shiu@health.wa.gov.au

Please note: Eligibility for service – 16-65years, concussion sustained within 12 months of referral, ongoing issues are primarily concussion related. The concussion program is a time limited service. GP involvement is required to support ongoing management. Persons with protracted alcohol or substance use are ineligible for this program.

NAME:
ADDRESS:
POSTAL ADDRESS (if different from above)**:**
PHONE: **EMAIL:**
CONTACT: ☐ **Patient** or ☐ **NOK**
INTERPRETER NEEDED ☐ **Yes** ☐ **No** **LANGUAGE:**
MARITAL STATUS: ☐ Married ☐ Partner ☐ Divorced/Separated ☐ Never married
ABORIGINAL OR TORRES STRAIGHT ISLANDER? ☐ **Yes** ☐ **No**
DOES THE CLIENT HAVE A GUARDIAN OR ENDURING GUARDIAN WITH THE FUNCTION OF MEDICAL DECISION MAKING? ☐ **Yes** ☐ **No** If yes, please provide details:
DATE OF CONCUSSION:
CAUSE OF CONCUSSION:
PAST MEDICAL HISTORY (including psychological and psychiatric history):
HOSPITAL / E.D. ADMISSION: ☐ **Yes** ☐ **No** **Date:**
GP DETAILS (Required)**:**
OTHER SERVICES INVOLVED (private services, medical specialist):

SOCIAL SITUATION: (include living arrangements, social supports, work, employment status, driving)

Are there any medicolegal issues including ☐ **Yes** ☐ **No**

ICWA: ☐ **Yes** ☐ **No**

workers compensation? ☐ **Yes** ☐ **No**

If yes, please provide details:

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

☐ **Behavioural** (e.g.: aggression, self-harm/suicide attempts, disinhibition, impulsivity, psychosis, personality change)

☐ **Forensic** (e.g.: criminal conviction/s, current charges pending, Violence Restraining Orders, Community Orders, domestic violence)

☐ **Psychosocial** (e.g.: home environment including risks from other occupants)

☐ **Alcohol/Substance Abuse***

Please note: any clients with active (or recent significant) alcohol or substance abuse are not eligible for the SHIU Concussion Pathway.

☐ **Other**

If 'Yes' to any of the above, please elaborate:

CONCUSSION SYMPTOMS (Brief summary of ongoing symptoms – attach any recent assessments):

PHYSICAL (incl. vestibular, balance, exertional, cervicogenic):

EMOTIONAL / BEHAVIOURAL:

SLEEP / FATIGUE:

COGNITION:

REASON FOR REFERRAL:

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

REFERRER:

ORGANISATION:

ADDRESS:

PHONE:

OFFICE USE ONLY: Referral taken by: _____

W:\Rehabilitation\SCG\SHIU\SHIUreferral form Last update will need updating once we have finalised