**WESTERN AUSTRALIAN ACQUIRED BRAIN INJURY REHABILITATION SERVICE**

**REFERRAL FORM**

Ground Floor E Block, Sir Charles Gairdner Hospital

**Ph**: 6457 4488 **Fax**: 6457 4489 **Email**: [shiu@health.wa.gov.au](mailto:shiu@health.wa.gov.au)

**Please note:**WAABIRS 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.

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| --- | --- | --- | --- | --- | --- | --- |
| **NAME:** | | | | **DOB:** | | **UMRN:** |
| **ADDRESS:** | | | | | | **POSTCODE:** |
| **POSTAL ADDRESS** (if different from above)**:** | | | | | | |
| **PHONE:** | | | | | | |
| **EMAIL:** | | | | | | |
| **CONTACT:** **Patient** or **Other - NAME and RELATIONSHIP:**  **PHONE:** | | | | | | |
| **ABORIGINAL OR TORRES STRAIGHT ISLANDER?** **Yes** **No** | | | | | | |
| **NESB?** **Yes** **No** | **INTERPRETER?** **Yes** **No** | | | | **LANGUAGE:** | |
| **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:** |
| **INPATIENT REHAB HOSPITAL:** | | | | **Admit date:** | | **D/c date:** |
| **REFERRED TO RITH?** **Yes** **No** | | | | **RITH D/c date:** | | |
| **OUTPATIENT 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** | |  | | | |  |
| **NDIS – Has an access request form been submitted prior to SHIU referral?** **Yes** **No**  **If so, please provide date submitted:** | | | | | | |
| **OTHER SERVICES INVOLVED:** | | | | | | |
| **GP:** | | | | | | |
| **Rehab Med Consultant:** | | | **Neurologist/Neurosurgeon:** | | | |
| **SOCIAL SITUATION:**(include living arrangement, social supports and discharge destination) | | | | | | |
| **MARITAL STATUS:** Married  Partner  Divorced/Separated  Never married | | | | | | |
| **DECISION MAKING ARRANGEMENTS:**  Informal  EPA  EPG  Administration  Guardianship | | | | | | |
| **PRE-ABI EMPLOYMENT STATUS:**  Fulltime  Part-time  Casual  Unemployed  Volunteer  Unknown | | | **Description of duties:** | | | |
| **Has clearance for RTW been provided at time of referral to SHIU?** **Yes** **No** | | | | | | |
| **DRIVING STATUS:**  Driving – medically cleared  Not driving – awaiting clearance  Driving – not medically cleared  **LICENSE TYPE:**  C Class (private)  C Class (commercial)  HR/MC Class  R Class  **Comments:** | | | | | | |
| **IMPAIRMENTS** (brief summary/list impairments & attach Ax’s – *please do not write “refer to attached ISoBAR”*)  **Insight:**  **Cognitive:**  **Physical** (include falls risk; precautions for transfers/ambulation)**:**  **Communication** (include aphasia; severe cognitive impairment)**:**  **Behavioural:**  **Sensory / Perceptual:**  **Psychological:**  **Seizures:** | | | | | | |
| **HOME VISIT RISK FACTORS?**  **Yes** **No** (if yes, please elaborate*)*  **Behavioural** (e.g.: aggression, self-harm/suicide attempts, disinhibition, impulsivity, Hx of psychosis)  **Forensic** (e.g.: any criminal conviction, current charges pending, Violence Restraining Orders, Community Orders)  **Psychosocial** (e.g.: home environment including risks from other occupants)  **Alcohol/Substance Abuse\***  **Other**  **If Yes to any of the above, please elaborate:**  ***\*Please note: any clients with active (or recent significant) alcohol or substance abuse will be required to engage in a program of support with drug & alcohol rehab services prior to SHIU referral being accepted.*** | | | | | | |
| **COMMUNITY REHABILITATION GOALS (REASON FOR REFERRAL):** | | | | | | |
| **ADDITIONAL INFORMATION:** | | | | | | |
| **IS THE CLIENT AWARE OF THIS REFERRAL?** **Yes** **No** (if no, please elaborate) | | | | | | |
| **ARE THEY A PREVIOUS WAABIRS CLIENT? Yes No Unknown** | | | | | | |
| **REFERRER:** | | | | **POSITION:** | | |
| **ORGANISATION:** | | | | | | |
| **ADDRESS:** | | | | | | |
| **PHONE:** | | | | **DATE OF REFERRAL:** | | |

**OFFICE USE ONLY:** **Referral taken by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ W:\Rehabilitation\SCG\SHIU\SHIUreferral form

Last update 17.09.2025