



Queensland Government

Princess Alexandra Hospital
 Spinal Injuries Unit
 Skin Management and Rehabilitation
 Team

SMART Referral Form

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Please fax referral to 1300 364 248

GP Details

GP Name

Address

Phone Number

Spinal Injury Diagnosis

Level of Injury (AIS) or Spina Bifida

Date of injury (if applicable)

Location(s), cause of pressure injury, date of onset

Current pressure injury management including any surgeries and dressing regimen

Wound Care Team / Nursing agency

Social situation

Lives alone Lives with:

Funding

NDIS NIISQ Other:
 My Aged Care (MAC), Level of package:
 Medical Aids Subsidy Scheme (MASS)

Care agencies

Home environment

Transport/ driving

Vocation/leisure

Cognitive/ mental health

Level of function (tick all that apply)

Mobility

Manual wheelchair Power wheelchair Walking
 Independent Assisted

Transfers

Hoist Horizontal transfers Slideboard Stand/pivot
 Independent Assisted

Self-cares

Bathing - Independent Assisted
 Dressing - Independent Assisted
 Feeding - Independent Assisted

Bowel management

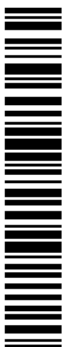
Independent Assisted
 Continent Incontinent
 Stoma MACE Spontaneously opening Other

Bladder management

Intermittent clean self-catheterisation IDC SPC
 Mitrofanoff Spontaneously voiding
 Independent Assisted Continent Incontinent

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V1.0 02/2022
 Locally Printed



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Medical Details

Weight: BMI:

Allergies:

Medication List:

Medical issues	Present?	Please provide details if you have ticked yes.
Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Peripheral vascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Malnutrition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is patient engaged with dietician?
Smoking/ ETOH/ recreational drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Poorly controlled spasticity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent autonomic dysreflexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	

INVESTIGATIONS

Please provide copies of the following if available:

- Full Blood Count
- ELFTs
- Folate, B12, Iron studies
- HBA1C
- ECG
- Echocardiography
- Respiratory Function Tests
- Renal surveillance scans (USS KUB/XR KUB or CT KUB)
- Wound swabs

Details of Health Professional Completing This Form

Name:	Position:
Organisation:	Phone number:
Signature:	Date:

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