2459

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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Medical Details

Weight: ..... BMI: .....

Allergies: .....

.....

Medication List: .....

.....

.....

.....

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