



Queensland
Government

Princess Alexandra Hospital
QSCIS Transitional Rehabilitation
Program (TRP) Referral Form

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Birth Sex: ☐ M ☐ F ☐ I

Patient details

Preferred Name:

Language spoken:

Interpreter required? ☐ Yes ☐ No

Date of Injury:

Mechanism of Injury:

Level of Injury / AIS:

☐ Known to QSCIS QuickStart

Other relevant injuries:

Weight:

Height:

PMHx:

Anticipated Date of Discharge:

Discharge Destination: ☐ Own Home ☐ Home Visit completed ☐ Modifications required

Funding Source

☐ NDIS - Participant Number:

☐ Awaiting Planning Meeting

☐ Plan Completed

☐ NIISQ - Participant Number:

Support Planner details:

☐ My Aged Care ☐ CHSP ☐ HCP Level ____ Package Secured ☐ Yes ☐ No Details:

☐ Other – Provide details:

Neurological Presentation

Bowel Management:

Pathway: ☐ Intact Function ☐ Upper Motor Neurone ☐ Lower Motor Neurone ☐ Other:

Evacuation: ☐ Spontaneous ☐ Enema/Suppository ☐ Digital Removal of Faeces ☐ Other:

Routine: ☐ AM ☐ PM ☐ Independent ☐ Requires assistance

Achieved Faecal Continence? ☐ Yes ☐ No Comments:

Bladder Management:

☐ Voids Completed Trial of Void date: Residual Volume:

☐ Indwelling Catheter ☐ Suprapubic Catheter ☐ Self Catheterisation ☐ Other:

Achieved Urinary Continence? ☐ Yes ☐ No Comments:

Skin: Wounds likely to require management on discharge? ☐ Yes ☐ No

Describe:

Respiratory: ☐ Respiratory Management Plan Required ☐ Sleep Disordered Breathing

Spasm: ☐ Upper limb ☐ Trunk ☐ Lower Limb ☐ Medicated ☐ Botulinum Therapy

Autonomic Dysreflexia: History of Autonomic Dysreflexia? ☐ Yes ☐ No

Education Given? ☐ Yes ☐ No

Social Barriers / Risks for discharge

Income Support: ☐ Employment ☐ Income Protection / Super ☐ Centrelink ☐ Other:

Adjustment / Mood / Mental Health Issues: ☐ Yes ☐ No

Behavioural Issues: ☐ Yes ☐ No

Substance Use Issues / History: ☐ Yes ☐ No

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Princess Alexandra Hospital

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URN:

Family name:

Given name(s):

Address:

Date of birth:

Birth Sex: ☐ M ☐ F ☐ I

Equipment

Mobility Aid: ☐ MWC ☐ PDWC ☐ Walking Aid ☐ Trialled ☐ Prescribed ☐ Hire ☐ Delivered

Backrest: ☐ Trialled ☐ Prescribed ☐ Hire ☐ Delivered

Cushion: ☐ Trialled ☐ Prescribed ☐ Hire ☐ Delivered

Transfer Aid: ☐ Trialled ☐ Prescribed ☐ Hire ☐ Delivered

Showering Aid: ☐ Trialled ☐ Prescribed ☐ Hire ☐ Delivered

Mattress: ☐ Trialled ☐ Prescribed ☐ Hire ☐ Delivered

Bed: ☐ Trialled ☐ Prescribed ☐ Hire ☐ Delivered

Community Powered Mobility Trial recommended? ☐

**Copies of script/quote for relevant assistive technology to be provided prior to discharge if accepted by TRP*

Physical Skills

I = Independent A = Assistance required D = Dependent

Rolling: ☐ I ☐ A ☐ D

Sitting Balance: ☐ I ☐ A ☐ D

Supine to Sit: ☐ I ☐ A ☐ D

Standing Balance: ☐ I ☐ A ☐ D

Sit to stand: ☐ I ☐ A ☐ D

MWC Skills: ☐ I ☐ A ☐ D

Mobility: ☐ I ☐ A ☐ D

Aid:

Personal Supports

Is personal care required for discharge: ☐ Yes ☐ No Agency Selected? ☐ Yes ☐ No

Plan for community access: ☐ Taxi ☐ Public Transport ☐ Private Transport ☐ Care Agency

Anticipated External Referrals on Discharge

☐ Physiotherapy ☐ Occupational Therapy ☐ Community Nursing ☐ Psychology

☐ Back 2 Work ☐ Other:

**Copies of relevant referrals to be provided prior to discharge if accepted by TRP*

Referring Service / Clinician

Referral to PAH SIU OPD completed (by Medical Team)? ☐ Yes ☐ No

Rehabilitation Outpatient Medical follow-up planned post-discharge? ☐ Yes ☐ No

Consultant:

Clinician Name (print name):

Designation/Service:

Signature:

Date:

Phone:

Email:

Please email the completed form to:

TRP@health.qld.gov.au

(07) 3176 9508

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