Royal Rehab
Empowering Independence

Brain Injury Telepsychiatry Service

Referral Date: _____

Referral to Brain Injury Telepsychiatry Service

Address:

Ph Number: **Mobile:**

Email:

Surname:

Given Names:.....

MRN (If current Royal Rehab client)

DOB: .....

Medicare No:

Next of Kin/Alternative Contact
Name: **Relationship:** **Phone Number:**

Country of Birth: **Interpreter Required:** ☐ **No** ☐ **Yes** **Language:**

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

Is the client Aboriginal/Torres Strait Islander?

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander

☐ Neither Aboriginal nor Torres Strait Islander ☐ Unknown

GP Name: **GP Phone No:** **GP Fax No:**

Client Marital Status:

☐ Single (never married) ☐ Widowed ☐ Divorced ☐ Separated ☐ Married/De Facto ☐ Unknown

Lives: ☐ Alone ☐ With Spouse/Partner ☐ With Parents ☐ Other Family Member

☐ Other, *please give details*:

Referring Service: ☐ **BIRP** ☐ **SSCIS** ☐ **iCARE** ☐ **COMMUNITY/GP** ☐ **LOCAL REHAB SPECIALIST**

Contact Name, Address, and Contact Details of Referring Service:

Treating Acute Service:

235 Morrison Road, Ryde NSW 2112
PO Box 6, Ryde NSW 1680 Australia
T. 02 9809 9000
F. 02 8415 8902
ABN 34 000 025 794
royalrehab.com.au

SURNAME: GIVEN NAME: DOB:

Has the client participated in an inpatient rehabilitation program?

☐ **Yes** ☐ Current ☐ Discharged Name of Service: _____

☐ No Second Service (if applicable): _____

Funding: ☐ Public ☐ NSW CTP ☐ iCare LTCS ☐ iCare Workers Care ☐ Workers Comp

☐ Interstate Motor Vehicle compensation ☐ NDIS ☐ My Aged Care ☐ Other Chargeable

Claim/Reference #: _____

Claim Status: ☐ Not lodged ☐ Pending ☐ Interim ☐ Compensable ☐ Non-compensable ☐ Unknown

Contact Details (NDIS Support Coordinator /Case Manager/Insurance Co-ordinator etc):

Date of Injury:

Rehabilitation Specialist:

Type of Injury:	☐ TBI (Traumatic Brain Injury)	☐ ABI: Acquired Brain Injury (Non-TBI)
Cause of Injury:	☐ MVA ☐ Non-MVA **Non-MVA categories:** ☐ Push bike/Scooter/skateboard/wheelchair ☐ Assault ☐ Sport related ☐ Fall ☐ Gunshot ☐ Fall from horse ☐ Unknown ☐ Other TBI, *specify*:	Acquired Brain Injury Cause: ☐ Hypoxia ☐ Stroke ☐ Infections ☐ Unknown ☐ Other non-TBI, *specify*:

PTA - Did the patient experience PTA? ☐ Yes ☐ No **Duration of PTA (days)**:_____

PTA range:

☐ <24 hours (mild) ☐ 1-7 days (moderate) ☐ 8-28 days (severe) ☐ 29-90 days (very severe)

☐ 91-183 days (very severe) ☐ >=184 days (chronic amnesic state)

REQUIRED ATTACHMENTS:

PROMIS-29 FORM completed and attached to the referral ☐ Yes ☐ No

Recent COGNITIVE TESTING completed and attached to the referral ☐ Yes ☐ No

Please indicate if you have included all other relevant paperwork to support the referral including discharge summaries, investigations, scan results and any other reports that will assist in this review. ☐ Yes ☐ No

SURNAME: GIVEN NAME: DOB:

REASON FOR REFERRAL TO BRAIN INJURY TELEPSYCHIATRY SERVICE

Please note: The Brain Injury Telepsychiatry Service is a pilot project operating from March 2023 through to mid-2024. This service may not continue after the completion of this pilot. It is a state-wide NSW service. **Preference will be given to referrals for patients who are not able to access face-to-face services.**

Please briefly outline the history of the injury AND why you are referring this client to the Brain Injury Telepsychiatry Service?

Reasons for requesting psychiatric review (can tick more than one):

☐ low mood ☐ unstable mood ☐ anxiety/panic attacks ☐ psychosis ☐ psychotropic medication review

☐ history of mental illness ☐ apathy/low motivation ☐ aggression ☐ disinhibition

☐ *other, please specify:*

Current Medical Diagnoses:

Other co-morbidities/complexities:

Has there been any acute change in health condition over the past 6 weeks? ☐ Yes ☐ No

If yes, please outline below:

Please indicate which other services are/will be involved with client:

List any **RISKS** that there might be for staff (i.e. behavioural concerns, infection risks etc):

CONSENT - MUST be completed by referee for the clinic to accept the referral

I have discussed a referral to the Brain Injury Telepsychiatry Service and client has given verbal consent to be contacted regarding this referral by the Brain Injury Telepsychiatry Service ☐

Referred By (Name and designation): _____

Submit Referral by: Fax (02) 8415-8902 OR Email: telepsychiatry@royalrehab.com.au