**St. George’s Hospital Craniospinal Trauma Referral Form**

**Every referral MUST have this form completed and emailed to**

[**stgh-tr.Neurotrauma@nhs.net**](mailto:stgh-tr.Neurotrauma@nhs.net)

**0830-1630 Mon-Thu Fri 0800-1600 Bleep 6027 via SGH switchboard**

**All other times** [**www.referapatient.org**](http://www.referapatient.org) **or Bleep 7242 for urgent clinical advice only**

**All fields are mandatory**

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| **Patient Details** | **Hospital Details** |
| **Surname** | **Referring Hospital** |
| **Forename** | **Your Name** |
| **Date Of Birth** **(dd/mm/yyyy)** | **Your Designation** |
| **NHS Number** | **Your Email**  **(NHS email)** |
| **Address** | **Bleep** **Mobile** |
| **Consultant** |
| **Postcode** | **Consultant Email       (NHS email)** |
| **Telephone** |  |
| **GP Name** | **Where is the** **patient currently?** |
| **GP Address** | **Hospital and** **Ward:       Contact Number:** |
| **Date of admission       (dd/mm/yyyy)** |

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| **Brief and Relevant Clinical Details** | |
| **Clinical History (MUST include presenting condition; motor & sensory status:**    **Exact date of first onset of symptoms:** **(dd/mm/yyyy)**  **Previous medical history:**     |  |  |  |  | | --- | --- | --- | --- | | **Respiratory** |  | **Details** |  | | **Cardiac** |  | **Details** |  | | **Other** |  | **Details** |  |   **Performance Status:**  **Prior to presentation:**  **Current Presentation:** | |
| **Please Fill the Relevant Section Depending on the Nature of the Patient’s Craniospinal Trauma** | |
| **Cranial Trauma**  **Describe the patient’s trauma:**     |  |  | | --- | --- | | What is the patient’s overall GCS score? |  | | Eye Opening Response | **Score** | | Verbal Response | **Score** | | Motor Response | **Score** | | **Spinal Trauma**  **Describe the patient’s trauma:**    Is the patient wearing a Spinal brace?  **Yes No**  Is the patient wearing a Cervical collar?  **Yes No** |
| **Continue on the Next Section** | |
| **Trauma History**  Is the patient on anticoagulants?  **Yes No**  If yes, what is the anti-coagulant the patient receives? **Choose Medication**  If other, please state the anti-coagulant used:  What are the neurological deficits the patient is suffering from due to their trauma?    **Comments:** | |

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| **Additional Information that may be useful to us** | |
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| Please send the completed form **immediately** via e-mail to  **stgh-tr.Neurotrauma@nhs.net**  If you need to discuss an emergency **Neurosurgical** referral out of office hours please contact via www.referapatient.org or the **Neurosurgical** **registrar on call (Bleep 7242)** at St George’s Hospital   |  |  | | --- | --- | | **Name of Neurosurgical registrar contacted:** |  | | **Date:** | **(dd/mm/yyyy)** | | **Time:** | **(24:00)** | | **Outcome:** |  | | For more information, you can visit the following webpages:  [**The Webpage for St. George’s University Hospitals Traumatic brain Injury Service**](https://www.stgeorges.nhs.uk/service/neuro/traumatic-brain-injury/)  [**St. George’s University Hospitals Traumatic Brain Injury Information Manual**](https://www.stgeorges.nhs.uk/wp-content/uploads/2013/10/94_Physiotherapy_Traumatic+brain+injury+-+an+information+manual.pdf) |