AlfredHealth

Alfred Health UR

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Referral to Victorian Acquired Brain Injury (ABI) Community Rehabilitation Service

The Acquired Brain Injury (ABI) Community Rehabilitation program provides a specialist service to people with a severe brain injury and their carers from the Victorian community. We also provide secondary consultation, education and advice to service providers working with people who have an acquired brain injury.

For additional referral and service information -

https://www.alfredhealth.org.au/services/hp/acquired-brain-injury-community-rehabilitation/

Eligibility Requirements

Review and check our eligibility criteria before completing a referral

- ❑ Client has a **moderate to severe acquired brain injury** of non-progressive pathology
- ❑ Client is 18 years or over
- ❑ Client must be medically stable and should have a GP willing to provide medical support (in consultation with a rehabilitation specialist available through our program).
- ❑ Client's rehabilitation goals or carer's needs **cannot be met by another public funded community service** (eg. local Community Rehabilitation Centre)
- ❑ Client will have potential to benefit from interdisciplinary intervention, by two or more Allied Health disciplines, to improve function, decrease disability, decrease level of care/ caregiver burden

NOT eligible if:

- ❑ Primary reason for referral is **return to work only**.
- ❑ Primary reason for referral is **behaviour management only**.
- ❑ Medico legal assessment and report (e.g., revoking Administration Order, testamentary capacity)
- ❑ Referral for home modifications, equipment prescription, services or case management for clients recently discharged from another service or funding body (e.g. NDIS)
- ❑ Requires only medical and/or single Allied Health discipline intervention

We also accept referrals for:

- ❑ Clients who need periodic review (monitoring) in the community to establish a plan of care to prevent complications and/or monitor for potential for rehabilitation (e.g., clients with Disorder of Consciousness)
- ❑ Local service providers requesting support to transition client to local services that may not have ABI expertise, (eg, provision of specialist and expert secondary consultation, education and advice to these services)

REFERRAL PROCESSING

Our Intake Triage Team operates Monday to Friday 08:30am to 4:30pm, excluding public holidays.
All referrals will be processed within 7 business days of receipt.

CONTACT US

For any queries, contact our service during business hours, Monday to Friday 8:30AM to 4:30PM (excluding public holidays): 9076 7423

Send Referrals to: E: abicommunity&tls@alfred.org.au or F: 9076 4841 – Attn: ABI Community Team

Family and Given Name/s _____

REFERRAL DETAILS

Date of referral		**Referring organisation**		**Ward**	
Address					
Referrers name		**Relationship to Client**			
Telephone		**Email**		**Referring service UR No.**	

CLIENT DETAILS

Family name		**Given name/s & preferred name**			
Date of birth		**Sex**	❑ Female ❑ Male ❑ Other		
Address				**Postcode**	
Telephone		**Email**			
Preferred contact method	❑ Telephone call ❑ Email ❑ SMS				
Medicare number		**Ref**		**Expiry**	
Funding body *If applicable, eg, NDIS, TAC*	**Coordinator name**			**Telephone**	
	Claim number				
Permanent Australian resident	❑ Yes ❑ No	**Language/s spoken**			
Interpreter required	❑ Yes ❑ No	**Interpreter language required**			
Aboriginal or Torres Strait Islander	❑ Not Aboriginal or Torres Strait Islander ❑ Torres Strait Islander not Aboriginal		❑ Aboriginal not Torres Strait Islander ❑ Aboriginal and Torres Strait Islander ❑ Prefer not to answer		

Medical Treatment Decision Maker (MTDM)	**Name**		**Relationship**		**Telephone**	
Guardian	**Name**		**Relationship**		**Telephone**	
Administrator	**Name**		**Relationship**		**Telephone**	
Enduring Power of Attorney (EPOA)	**Name**		**Relationship**		**Telephone**	
	Type		❑ Financial / Legal	❑ Personal		
Primary contact	**Name**		**Relationship**		**Telephone**	
Is the client / family aware of referral	❑ Yes ❑ No	Comments				
GP name				**GP telephone**		
GP address				**GP fax**		
Current inpatient / community rehabilitation admission details						
Discharge destination			**Discharge date**			

ACQUIRED BRAIN INJURY & CURRENT HEALTH STATUS

Reason for referral	❑ Active therapy ❑ Monitoring ❑ Consulting ❑ NDIS service provision

ACQUIRED BRAIN INJURY & CURRENT HEALTH STATUS *cont*

Disciplines required	❑ Social Work ❑ Speech Pathologist ❑ Dietitian ❑ Community Nursing	❑ Occupational Therapist ❑ Exercise Physiologist ❑ Neuropsychologist	❑ Clinical Psychologist ❑ Allied Health Assistant ❑ Physiotherapist	
Type of brain injury	❑ Traumatic	❑ Hypoxic	❑ Stroke	❑ Substance related (*includes alcohol*)
	❑ Other non-traumatic brain dysfunction			
Details *How and when did the brain injury occur? Include severity indicators as appropriate (eg, PTA, downtime etc)*				
Medical history; Mental health history & current; Seizure history				
Drug / alcohol / smoking history				
History of behavioural / forensic issues				
Current medications (*or add separate list)*				
Any related risks identified				
Allergies				

PREMORBID FUNCTION & SOCIAL HISTORY

Lives with	❑ Alone	❑ Spouse / partner	❑ Children	❑ Parents ❑ Friends
Psychosocial	Family / other support			
Accommodation	❑ Private owned residence ❑ Supported residential service ❑ Shared supported accommodation ❑ Other (*specify*) _____	❑ Private rental ❑ Residential care ❑ Housing commission	❑ Homeless ❑ Boarding house	
Premorbid Personal ADL ie *personal care / domestic / community access / driving / cognition / mobility / vocational / study / volunteering / leisure & recreation*				

Family and Given Name/s _____

CURRENT FUNCTION LEVEL & CARE NEEDS

Cognition *(memory / attention / executive function / insight*		
Visual / Perception *(visual field deficits / neglect / dyspraxia)*		
Language (*Expression / comprehension / social interaction / aids / strategies)*		
Hearing	❑ NAD ❑ Hearing aid ❑ Other (*specify)*	
Nutrition (*Malnutrition risk, obesity)*		
Diet (*modified / enteral nutrition*)		
Upper limb function / lower limb function / weight bearing restriction *etc*		
Transfers	❑ Independent ❑ Supervised ❑ 1 Person Assist ❑ 2 Person Assist ❑ Hoist	
Ambulation / mobility	❑ Independent ❑ Supervised ❑ 1 Person Assist ❑ 2 Person Assist ❑ Hoist	
Aids (*specify*)		
Current functional performance	Self care	❑ Independent ❑ Supervised ❑ Requires Assistance
	Domestic	❑ Independent ❑ Supervised ❑ Requires Assistance
	Community	❑ Independent ❑ Supervised ❑ Requires Assistance
	Vocational	❑ Independent ❑ Supervised ❑ Requires Assistance
Continence	Bladder	❑ Continent ❑ Incontinent ❑ Indwelling Catheter ❑ Uridome ❑ Other (*specify*) _____
	Bowel	❑ Continent ❑ Incontinent ❑ Other (*specify*) _____
Current behaviour / support strategies		

Family and Given Name/s _____

REFERRAL GOALS

Short term goals for active therapy OR **Objectives for monitoring**		
Long term goals and objectives		
Other referrals made / support services involved (CRP / NDIS)		
Other important details		
Attached documents	❑ Discharge Summary ❑ Neuropsychological Report ❑ Medical Reports	
	❑ Discipline assessments	
	❑ Other	

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