**ORTHOPAEDIC PELVIC AND ACETABULAR REFERRAL FORM**

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| **DEMOGRAPHICS** |
| Patient Name |  |
| DOB |  |
| MRN |  |
| Referring Hospital |  |
| Admitting Consultant |  |

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| **PRESENTING COMPLAINT** |
| Date of injury |  |
| Mechanism of injury |  |
| Reason for referral to TUH |  |
| Other concurrent injuries |  |
| **Neurological injury*** Document presence or absence of lower limb neurology
* Document any other neurology
* Document any change in neurology from admission to current status
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| **Vascular injury*** Document presence or absence of any vascular injury
* Document any change in vascular status from admission to current status
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| **Urological injury*** Document any suspected urological injury
* Comment on presence or absence of haematuria on dipstick
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| Has the patient required any interventions in your hospital since admission? If so, please detail.(e.g. transfusion, traction, laparotomy etc.) |  |
| List all imaging that the patient has had done since admission*Note: Most patients will require an x-ray (AP Pelvis and Judet views) and CT pelvis prior to referral to TUH* |  |

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| **PATIENT MEDICAL HISTORY** |
| Previous Medical History |  |
| Previous Surgical History |  |
| Regular Medications |  |
| Allergies |  |
| Family History |  |
| Social History*(C2H5OH intake, smoking status, profession, mobility status)* |  |
| Infection statusDocument any history of Multidrug Resistant Organisms (MDROs) or other Infection Risks: *(e.g. MRSA/ ESBL/ Clostridium Difficile / CRE/MDR Pseuodomonas)* |  |

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| **CURRENT STATUS** |
| Airway |  |
| Breathing* *Requiring supplementary oxygen?*
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| Circulation* *Requiring ionotropic support?*
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| Disability |  |
| Environment |  |
| GCS* Admission GCS
* Current GCS
 |  |
| Injury Severity Score |  |
| Date and result of most recent Covid-19 swab |  |

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| **BLOODS** |
| **Haematology** |
| HB |  | PLT |  |
| WCC |  | INR |  |
| **Biochemistry** |
| Total protein |  | ALT |  |
| Albumin |  | Alk Phos |  |
| Total Bilirubin |  | GGT |  |
| Sodium |  | Potassium |  |
| Creatinine |  | Urea |  |
| CRP |  | Lactate |  |

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| **TRANSFER STABILITY STATUS** |
| Is patient currently haemodynamically stable? *(choose one)* | YES / NO |
| If patient is not currently stable, please provide details |  |
| Is there a timeline before this patient is anticipated to be stable? |  |
| Does the patient require further surgery before transfer to TUH? |  |
| What is patient’s current level of care requirement? | WARD HIGH DEPENDENCYINTENSIVE CARE |

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| **REFERRING DETAILS** |
| Referring Doctor name & MCRN |  |
| Contact details of referring Doctor |  |
| Name of Doctor contacted in TUH |  |
| Date and time of call |  |