**REFERRAL / ASSESSMENT FORM PELVIC AND ACETABULAR FRACTURES**

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| **DATE of referral** |  | |
| **QEUH Registrar in receipt of referral** |  | |
| **Referring Unit & Ward** |  | |
| **Referring Consultant with email** |  | |
| **Person submitting referral with telephone number** |  | |
| **Patient name, CHI & home address** |  | |
| **PMH**  In addition to detailed PMH, please ensure details re previous abdominal/groin surgery is included in detail |  | |
| **Pre-trauma functional status**  eg. Mobilises independently, mobilises with Zimmer frame etc. |  | |
| **Date & Mechanism of injury** |  | |
| **Description of pelvic injury** |  | |
| **Associated /other injuries** | 1.  2.  3.  4. | |
| **Thromboprophylaxis prescribed & date started** |  | |
| **Laxative prescribed & date started** |  | |
| **Clinical course & treatment since injury**  Eg. Treatment for chest infection, requiring Abx, O2 requirements |  | |
| **Examination:** |  | |
| L4/5/S1 power | **(L)** | **(R)** |
| L4/5/S1 sensation | **(L)** | **(R)** |
| Peripheral pulses | **(L)** | **(R)** |
| Confirm catheter in situ +/- evidence of urethral injury |  | |
| Evidence of perineal injuries | YES / NO | |
| Evidence of rectal/vaginal injuries | YES / NO | |

### Contact Details

Refer via Orthopaedic Registrar on call 0141 452 2735 / 82735 **and** email completed form to Pelvic.Trauma@ggc.scot.nhs.uk

In relation to referrals in progress, the Trauma & Orthopaedic ANP on call can be contacted via 0141 452 2737 / 82737

### For use at Pelvic MDT

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| **DATE OF MDT** |  |
| **CONSULTANTS PRESENT/INVOLVED IN DISCUSSION** | M Kelly, L Campton, A Marsh, S Gill |
| **IN CASE OF PATIENT TRANSFERRED TO QEUH PRIOR TO MDT, PATIENT SEEN IN PERSON BY** |  |
| **ADMISSION NOTE DICTATED** | YES/NO |
| **DIAGNOSIS** |  |
| **SUMMARY MANAGEMENT PLAN** | OPERATIVE / NON OPERATIVE |
| **STATUS AT TIME OF MDT** | PRE-OP / POST-OP / NA |
| **MANAGEMENT PLAN DETAILS /RECOMMENDATIONS** | Transfer to QEUH for operative management, including timing of transfer, expected surgery date and interventions required prior to transfer  *OR*  Conservative management inc. weight bearing status, repeat radiology required and follow up plans |
| **THROMBOPROPHYLAXIS ADVICE** |  |
| **ADDITIONAL NOTES** |  |
| **NAME OF COMPLETING CONSULTANT** |  |