**REFERRAL / ASSESSMENT FORM SPINAL TRAUMA**

Please refer to the **Spinal Trauma Guidelines for Referring Hospitals** when referring patients to the Spinal MDT.

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| **DATE of referral** |  | |
| **REASON for referral**  Treatment or follow up |  | |
| **QEUH Registrar in receipt of referral** |  | |
| **Referring Unit & Ward** |  | |
| **Referring Consultant with Email** |  | |
| **Person submitting referral with telephone number** |  | |
| **Patient Name, CHI & Home Address** |  | |
| **Past Medical History** |  | |
| **Drug History** |  | |
| **Social History** |  | |
| **Pre-trauma functional status**  e.g. Mobilises independently, mobilises with Zimmer frame etc. |  | |
| **DATE and TIME of injury** |  | |
| **MECHANISM of Injury**  Please specify if traumatic / atraumatic |  | |
| **CLASSIFICATION of spinal injury**  As per AO +/- TLICS Classification |  | |
| **Associated injuries** | 1.  2.  3. | |
| **Imaging so far** Include modalities |  | |
| **Clinical course & treatment since injury** |  | |
| **Has patient been discussed with neurosurgery?**  Include outcome if answer is yes. | YES / NO | |
| **Neurological Examination:** |  | |
| Upper limb power C5-T8 (MRC) | **(R)** | **(L)** |
| Upper limb sensation C5-T8 | **(R)** | **(L)** |
| Upper limb reflexes | **(R)** | **(L)** |
| UMN/LMN Signs  **e.g. clonus/Hoffmann sign/fasciculations/atrophy** | **(R)** | **(L)** |
|  |  |  |
| Lower limb power L2-S1 (MRC) | **(R)** | **(L)** |
| Lower limb sensation L2-S1 | **(R)** | **(L)** |
| Lower limb reflexes | **(R)** | **(L)** |
| UMN/LMN Signs  **e.g. clonus/Babinski sign/fasciculations/atrophy** | **(R)** | **(L)** |
| PR examination findings |  | |
| For spinal fracture: any evidence of posterior bruising/swelling/tenderness? |  | |
| Evidence of new onset bladder dysfunction?  **If answer is yes, perform pre- and post-void scan** | YES / NO | |
| Completed ASIA Chart   1. **On arrival** 2. **Day 1 post admission** 3. **Pre-intervention** 4. **Post-intervention**   **(patient will also require an ASIA chart assessment prior to transfer if for transfer)** | YES / NO | |

### Contact Details

Refer via Orthopaedic Registrar on call 0141 452 2735 / 82735 **and** email completed form to all of the Spinal Consultants:

[alex.augustithis@nhs.scot](mailto:alex.augustithis@nhs.scot), [nicholas.brownson2@nhs.scot](mailto:nicholas.brownson2@nhs.scot), [niall.craig@nhs.scot](mailto:niall.craig@nhs.scot), [fraser.dean2@nhs.scot](mailto:fraser.dean2@nhs.scot), [anthony.gibson2@nhs.scot](mailto:anthony.gibson2@nhs.scot)

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

### For use at Spinal MDT

|  |  |
| --- | --- |
| **DATE OF MDT** |  |
| **CONSULTANTS PRESENT/INVOLVED IN DISCUSSION** | A Augustithis, N Brownson, N Craig, F Dean, A Gibson, |
| **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 |
| **FURTHER ADVICE** |  |
| **ADDITIONAL NOTES** |  |
| **NAME OF COMPLETING CONSULTANT** |  |