Referral to Spina Bifida Adult Resource Team

Date:

Hospital or Service Provider Name			
Surname	**First name**	**Date of birth**	**Gender** Male Female
Address			

Home phone number	**Mobile number and email address**

Other reliable contact	**Address of other contact**	**Phone number of other contact** **Mobile number**

Interpreter required Yes No	**Language Spoken at Home:**
Primary diagnosis	**Co-morbidities**

Reason for Referral to Spina Bifida Adult Resource Team and any priorities for management.

Has a Spina Bifida Transition Plan been completed?

Education / Employment Status

- ☐ School (which year)
- ☐ Preparing for Uni /TAFE
- ☐ TAFE
- ☐UNI
- ☐ Work (? Full or part –time) What type and Where …………………………………………..
- ☐ Other …………………………………………

Living Arrangements

- ☐ Lives with family
- ☐ Lives Alone
- ☐ Lives with other (Not Family Member)

Receives Personal Care Yes ☐ No ☐

If Yes where from

- ☐ Home Care/ Attendant Care
- ☐ Family

Paediatric/Adult service details (if applicable list all clinicians involved and their speciality)	**Proposed adult service details (if applicable list all relevant clinicians and their speciality)**

Recommended first appointment at adult service

______/_______/_______

Suggested Place for Initial Contact and Assessment.

- ☐ Next Clinic Appointment
- ☐ Home Visit
- ☐ Other ………………………………………

Client Consent: I, the client agree for this referral to be passed onto the Spina Bifida Adult Resource Team and to be contacted by the staff of the Spina Bifida Adult Resource Team.

Name: **Signature:**

Please fax or email the completed form to Joanne Brady, Team Leader SB Adult Resource Team on 9482 9177. Phone 9472 5214; Joanne.Brady@northcott.com.au