Neurosurgical Referral Proforma

Referring Hospital		**Consultant**		
A&E Number		**Hospital No.**		
Name		**Sex**	Male □	Female □
Age		**Date of Birth**		

Date of Incident		**Time of Incident**	:	**Time of Admission**	:
History					

Physiological Observations	Time	HR	BP	RR	SpO_2	GCS			R. Pupil		L. Pupil	
						E	M	V	Reacts	Size	Reacts	Size
On Arrival												
On Transfer												

CT Scan at Referring Hospital	Yes □	No □	Time Requested	:	Time Performed	:
Cranial Injuries						
Spinal Injuries						
Date and time of referral to Neurosurgery						

Extracranial Injuries (Proven or Suspected)	
Pelvis	
Limbs	
Chest	
Abdomen	
Face/Neck	
Other (Specify)	

Past Medical History	
Current Medications	
Anticoagulants	

Interventions					
Airway	Guedel □	ETT □	Oro/Nasogastric Tube	Yes □	No □
Ventilation	Spontaneous □	IPPV □	Urinary Catheter	Yes □	No □

Drugs Given	Dose	Time
Tetanus toxoid		
Vitamin K		
Beriplex		

IV Fluids	Volume
Crystalloid	
Colloid	
Blood	

Time			
pO_2			
pCO_2			
H^+			
HCO_3^-			

Time		**Time**	
Hb		Na^+	
WCC		K^+	
Platelets		Urea	
PT		Creat	
APTT		Glucose	

Next of Kin		Tel no:		Notified	Yes □	No □

Transfer with the Patient				
Observation Charts □	Medical Notes □	Imaging □	Linked □	Hard Copies □

Signed		**Print**		**GMC No.**	
Receiving Neurosurgeon		**Grade**		**Transfer Time**	: