

NEUROSURGICAL REFERRAL LETTER

Scottish Trauma Audit Group

Referring Hospital: _____ Consultant: _____ A & E Number:

Name: _____ Sex: male female Age:

Address: _____ DOB:

Date of Incident: Time of Incident: : Time of Admission: :

History: _____

Physiological Observations

	Time	HR	BP	RR	O ₂ sat	GCS			Right Pupil		Left Pupil	
						eye	motor	verbal	reacts	size	reacts	size
on arrival												
on transfer												

Cranial Injuries: _____

Extra-Cranial Injuries: *(proven or suspected)* CT Scan at referring hospital: Yes No

C-spine: _____ Chest: _____
 Pelvis: _____ Abdomen: _____
 Thoracolumbar: _____ Face/Neck: _____
 Limbs: _____
 Other: (specify) _____

Past Medical History: _____

Current Medication: _____

Interventions

Airway: Guedel ETT Other None

Ventilation: Spontaneous IPPV

Nasogastric tube: Yes No

Urinary catheter: Yes No Urinalysis: _____

Drugs given	Dose	Time
Tetanus Toxoid		

IV Fluids	Volume
crystalloid	
colloid	
blood	

Time			
pO ₂			
pCO ₂			
H ⁺			
HCO ₃			
on			
%O ₂			

Time		Time	
Hb		Na ⁺	
WCC		K ⁺	
Platelets		Cl ⁻	
Glucose		HCO ₃	
X-match		Urea	
		Creat.	

Next of Kin: _____ Tel. No. _____ Notified: yes no

Valuables: patient relatives police none Clothing: patient relatives police none

NB: Have you excluded all possible sites of blood loss?

Transfer with the patient: Observation charts Medical notes X-rays

Signed: _____ Print: _____ Grade: _____

Receiving Neurosurgeon: _____ Grade: _____ Transfer Time: :