



**Queensland
Government**

Trauma Recovery and Rehabilitation Plan

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

For assistance completing this plan, refer to the *Instructions for completing the Trauma Recovery and Rehabilitation Plan* available at <https://clinicalexcellence.qld.gov.au/resources/trauma-recovery-and-rehabilitation-plan>. This form is to be completed by a key member from the treating team, working collaboratively with the team providing assessment and intervention during the admission.

Admission date: **Estimated date ready for transfer/discharge:**

Previous transfers (location and date):

Current location/ward:

Treating team key contact details:

Reason for admission (include date of injury, list of injuries, management plan, weight bearing status, review dates):

Relevant medical history:

Infectious precautions:

Allergies: Nil known

Significant events/complications:

Social Situation

Lives alone Lives with other – Name(s): Relationship:

Carer/supports name:

Contact number: **Relationship:**

Enduring Power of Attorney: Yes No Details:

Advanced Health Directive: Yes No Details:

Identifies as: Aboriginal Torres Strait Islander Both Neither Unknown

Indigenous Liaison/Health worker required: Yes No Details:

Preferred language: English Other:

Interpreter required: Yes No Details:

Existing community services: Yes No Details:

Residential care: Yes No Details:

Other services: Yes No Details:

General Practitioner (name and practice contact):

DO NOT WRITE IN THIS BINDING MARGIN

TRAUMA RECOVERY AND REHABILITATION PLAN





**Queensland
Government**

Trauma Recovery and Rehabilitation Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Social Situation *(continued)*

Finances: Employed Income support payment Self-funded Details:

Funding: N/A Centrelink NDIS DVA Private Health Details:

National Injury Insurance Scheme: N/A New Eligible Details:

National Disability Insurance Scheme: N/A New Eligible Details:

My Aged Care: Yes No Details:

Home Environment

Type of dwelling: House Unit High-set Low-set Two-story Other:

Ownership: Owner-occupied Private rental Dept of Housing property Other:

Equipment and home modifications in place:

Number of steps into home: **Air conditioning:** Yes No **Internal heating:** Yes No

Shower/toilet access and location:

Occupational Therapist home visit recommendations:

Additional details:

Pre-admission Function

Mobility: Independent Standby assistance Assistance: Assistive equipment used:

Transfers, balance:

Falls history:

Upper limb impairment noted: Yes No Details:

Personal care/hygiene:

IADLs:

Continent – Bowel: Yes No **Bladder:** Yes No

Details/assistive aids used:

Medication management: Independent Requires assistance

Details/assistive aids used:

Work history:

Driving history: Does not drive Drives: Automatic Manual

Experience/comments:

Cognition impairment noted: Yes No Details:

Sensory – Hearing: **Vision:** **Taste:**

Other:

DO NOT WRITE IN THIS BINDING MARGIN



Trauma Recovery and Rehabilitation Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Current Function

Mobility, transfers, balance:

Upper limb impairment noted: Yes No Details:

Personal care/hygiene:

IADLs:

Continent – Bowel: Yes No Bladder: Yes No

Details/assistive aids used:

Medication management: Independent Requires assistance

Details/assistive aids used:

Cognition impairment noted: Yes No Details:

Sensory – Hearing: Vision: Taste:

Nutrition:

Weight (kg):

Height (cm):

Swallowing difficulties/recommendations:

Communication impairment noted: Yes No

Details:

Wound management:

Mood impairment noted: Yes No Details:

Pain management:

Other:

Recommendations

Patient goals:

Specialist medical needs:

Number and types of disciplines (consider patient goals above):

- Physiotherapy
- Occupational therapy
- Social work
- Speech pathology
- Dietetics
- Alcohol, Tobacco, and other Drugs Services (ATODS)
- Chronic disease management
- Exercise physiology
- Hydrotherapy
- Mental Health
- Neuropsychology
- Orthotics
- Podiatry
- Prosthetics
- Psychology
- Stomal therapy
- Other:

Frequency of therapy:

Psychosocial complexity:

- Complex capacity/consent issues
- QCAT/EPOA/Substitute decision-maker issues
- NDIS/NIISQ application
- Accommodation issues
- Other complex psychosocial barriers

Equipment: None Basic: Specialised:

DO NOT WRITE IN THIS BINDING MARGIN



**Queensland
Government**

Trauma Recovery and Rehabilitation Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Recommendations *(continued)*

Rehabilitation setting:

- Level 5/6 specialist/complex rehabilitation unit
- Level 4 moderately complex care needs
- Geriatric Evaluation & Management
- Level 3 inpatient, low-risk, low complexity

- Level 2 inpatient, multipurpose centre
- Community/Primary Health
- Other:

Destination:

Additional details:

Patient's preference:

Patient consented to referral(s): Yes No Details:

Patient suitable to participate in rehabilitation: Yes No Details:

Patient ready to participate in rehabilitation: Yes No Details:

Patient suitable and agreeable to telehealth: Yes No Details:

Referral(s) completed:

Reason for variance if recommendations different to discharge plan:

Review/plan date:

Comments/plan:

Additional Information

Completed by:

Information obtained via:

Date sent:

Trauma Recovery Plan (this document) sent to:

Please provide feedback regarding this form to: QldRehabilitationNetwork@health.qld.gov.au