ARKANSAS SPINAL CORD COMMISSION
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Central Registry Referral Form

ASCC-1a
12/2018

CLIENT/PATIENT INFORMATION

Trauma Band Number (if applicable) ____________________

Name ____________________ **Parent/Next of Kin** ____________________

Address ____________________ **Phone No.** ____________________

____________________ **Date of Birth** ____________________

City State Zip Code County

SSN ____________________ **Gender** __________ **Marital Status** __________ **Dependents** ________

Veteran Yes No **Service Connected** Yes No

Worker's Comp Yes No

MEDICAL INFORMATION

Neurological Level Check One: Paraplegia Tetraplegia Unknown **Date of Onset** ____________

Cause of Disability ____________________ **Vertebral Level** ____________

Extent of Disability Check One: Complete Incomplete Unknown **Date of Admission** ____________

Referred By ____________________ **Agency** ____________________ **Phone No.** ____________

Attending Physician ____________________ **Phone No.** ____________

Hospital ____________________ **Room No.** ____________

Admitted From: ____________________

Central Registry Referral Form Instructions

CLIENT/PATIENT INFORMATION

Trauma Band No.: Enter client's Arkansas Trauma System trauma band number (if applicable).
Client Name: Enter the full name of the client (include Jr., Sr., II or III, if applicable.)
Parent/Next of Kin: Enter the full name(s) of the child's parents or legal guardian or the patient's Next of Kin.
Address: Enter the address (street number and name, city, state, ZIP (and P.O. Box, if applicable) where the patient resides.
Phone No.: Enter the client's telephone number (be sure to include area code) or contact telephone number.
Date of Birth: The client's date of birth.
Social Security No.: Enter the client's social security number, if available.
Gender: The client's gender.
Marital Status: The client's marital status, if known.
Dependents: Number of dependents living in the home, if known (this includes children, grandchildren, etc.).
Veteran: If applicable (is the client a veteran of active military service?).
Service Connected: Was the SCI/D sustained during active military service?
Workers' Comp: Was the SCI/D sustained during a work-related activity?

MEDICAL INFORMATION

Neurological Level: Paraplegia, tetraplegia, or unknown.
Date of Onset: For trauma cases, date of injury. For non-trauma cases, date the disease was diagnosed.
Cause of Disability: Motor vehicle accident (MVA); birth defect; surgery; disease process; etc.
Vertebral Level: T10, C4, etc., if known.
Extent of Disability: Complete or incomplete, if known.
Date of Admission: Date the patient was admitted to the referring facility
Referral By: Name, agency, and telephone number of the person making the referral.
Attending Physician: Name and telephone number of the client's attending physician.
Hospital: Name of hospital if client is hospitalized.
Room No.: Hospital room number, if client is hospitalized.
Admitted From: Hospital or facility that the patient was admitted to prior to the referring entity (if applicable).