



<b>*Sensory Assessment</b>	Dermatomes	C5	C6	C7	C8	T1		
	Normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Altered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Absent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Investigation Results</b>  (brief summary – if you have full reports please leave blank and send separately)	MRI / CT-myelography:					Date:	<input type="text"/>	
	Chest X-ray:					Date:	<input type="text"/>	
	C-spine X-ray:					Date:	<input type="text"/>	
	Neurophys:					Date:	<input type="text"/>	
<b>Brachial Plexus Details</b>	Side Affected:	<input type="checkbox"/> L <input type="checkbox"/> R	Open or Closed Injury:	<input type="checkbox"/> Open <input type="checkbox"/> Closed	Horner's Sign:	<input type="checkbox"/> Y <input type="checkbox"/> N	Arterial Injury:	<input type="checkbox"/> Y <input type="checkbox"/> N
	Pulses Present Affected Limb:	<input type="checkbox"/> Y <input type="checkbox"/> N	If pulses absent, is there critical limb ischaemia?		<input type="checkbox"/> Y <input type="checkbox"/> N	Tinel's:	<input type="checkbox"/> Y <input type="checkbox"/> N	
	Site of Bruising:	<input type="text"/>		Fractures /Dislocations:	<input type="text"/>			
<b>Past Medical History</b> (Brief)	<input type="text"/>							
<b>Medications</b>	<input type="text"/>							
<b>Other</b>	MRSA Status:	<input type="text"/>	Date Swabs Taken:	<input type="text"/>	Drugs (VDA)?	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N

<b>*Referrer:</b>	<input type="text"/>	<b>*Designation/ Department:</b>	<input type="text"/>
<b>*Hospital/Location:</b>	<input type="text"/>	<b>*phone/email:</b>	<input type="text"/>
<b>*Consultant (if different from above):</b>	<input type="text"/>	<b>phone/email:</b>	<input type="text"/>
<b>Therapist /Other:</b>	<input type="text"/>	<b>phone/email:</b>	<input type="text"/>

Save as a Word Document or PDF then email to:

[brachial.plexus@ggc.scot.nhs.uk](mailto:brachial.plexus@ggc.scot.nhs.uk)

Or by post to:-

Brachial Plexus Injury Service  
Trauma & Orthopaedics  
REH030 Therapies Department  
New Victoria Hospital  
GLASGOW  
G42 9LF