ARKANSAS SPINAL CORD COMMISSION
Central Registry Referral Form

ASCC-1a
01/2022

5800 West 10th Street, Suite 108,
Little Rock, AR 72204

501-296-1788 1-800-459-1517
501-296-1787 (fax)
ascc@arkansas.gov (email)

CLIENT/PATIENT INFORMATION

Trauma Band Number (if applicable) _____

Name _____ **Parent/Next of Kin** _____

Address _____ **Phone No.** _____

_____ AR _____ **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

ELIGIBILITY CRITERIA

In order to qualify for services from ASCC, referrals **must be an Arkansas resident** and must present a spinal cord injury or disability that meets at least **THREE of the FOUR** following conditions: 1. Loss of motor function. 2. Loss of sensation. 3. Loss of bladder control 4. Loss of bowel control. **Arkansas law ACA 20-8-206 requires that referrals must be made within 5 days of diagnosis/identification.**

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
Referred By: Name, affiliation, and telephone number of 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).