

Mission:

To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

**Ron DeSantis**

Governor

Joseph A. Ladapo, MD, PhD

State Surgeon General

Vision: To be the Healthiest State in the Nation

Scan Code for
Online Portal



BRAIN AND SPINAL CORD INJURY PROGRAM CENTRAL REGISTRY **SELF REFERRAL FORM**

*Items marked with a red asterisk is required information

Referral Date:

*Injury:

Social Security #:

*Last Name:

*First Name:

M. I.:

Suffix:

* Homeless: *

Address:

Apt/Unit:

City:

*Zip Code:

State:

County:

Phone#:

*Date of Birth:

*Sex:

Race:

Supportive Contact Last Name:

Supportive Contact First Name:

Supportive Contact Phone #:

Relationship to client:

What was the date of the injury:

What county did the injury occur in?

What activity was the client doing when the injury happened?

What date were you admitted to the hospital?

What position were you in?

What caused the injury?

*Were you or are you on a ventilator? Yes

No

BRAIN INJURY INFORMATION

Do you have altered senses?

Yes

No

*Rancho Score:

*Glasgow Score:

*Open/Closed:

SPINAL CORD INJURY INFORMATION

Do you have any of the following?

Sensory Deficit:

Yes

No

Motor Deficit:

Yes

No

Bowel/Bladder Deficit:

Yes

No

*Para/Quad Level:

Extent of Lesion:

Current physician name:

Phone #:

Address, City, State, Zip:

Revised 6/16/2025

Florida Department of Health**Brain and Spinal Cord Injury Program**

4052 Bald Cypress Way, Bin C-25 • Tallahassee, FL 32399

PHONE: 850-245-4045 • FAX: 850-410-1975

BSCIPCcentralRegistry@flhealth.gov**FloridaHealth.gov**

Accredited Health Department
Public Health Accreditation Board

**Instructions for completing the
SELF Referral Form for the
Brain and Spinal Cord Injury Program**

PATIENT / CLIENT REFERRAL INFORMATION	RESPONSE (S) NEEDED
*Injury	Select one of the following: Brain Injury Dual Injury (Brain and Spinal Cord) Spinal Cord Injury
Social Security #	Enter the patient / client's social security number.
*Name	Enter last name, first name, and middle initial. If Suffix is part of the name, enter in Suffix field of form
*Homeless	Enter Yes if homeless and leave address fields blank Enter No if you have an address
*Address	Enter the patient / client's residential street location.
Apt/Unit	Enter the Apartment or Unit number if applicable. Otherwise, leave blank.
*City	Enter the name of the city where the patient / client resides.
*Zip Code	Enter the Zip Code of the patient / client's residence.
*State	Enter the State where the patient / client resides.
*County	Enter the name of the county of the patient / client's residence.
Phone	Enter the area code and phone number of the patient / client's residence.
*Date of Birth	Enter date of birth as mm/dd/yyyy (month/day/year)
*Sex	Enter "M" or "F" or Unknown

PATIENT / CLIENT REFERRAL INFORMATION	RESPONSE (S) NEEDED																																								
Race	Select one of the following: A - Asian (Not Hispanic or Latino) B - Black or African American (Not Hispanic or Latino) H - Hispanic or Latino I - American Indian or Alaska Native (Not Hispanic or Latino) P - Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino) R - Not Recorded T - Two or More Races (Not Hispanic or Latino) U – Unknown W - White (Not Hispanic or Latino) Y - Prefer not to answer																																								
Supportive Contact Name	Enter the name of a responsible party who can be contacted in the daytime regarding the patient / client.																																								
Supportive Contact Phone Number	Enter the area code and phone number where the supportive contact can be reached.																																								
Relationship to Client	Enter the selection that best describes the relationship between the Supportive Contact and the patient/ client: <table border="0"> <tr> <td>Aunt</td> <td>Nephew</td> </tr> <tr> <td>Brother</td> <td>Other Family Members</td> </tr> <tr> <td>Brother-in-Law</td> <td>Other Official</td> </tr> <tr> <td>Child</td> <td>Parent</td> </tr> <tr> <td>Daughter</td> <td>Physician</td> </tr> <tr> <td>Daughter-in-Law</td> <td>School Contact</td> </tr> <tr> <td>Ex-Spouse</td> <td>Significant Other</td> </tr> <tr> <td>Facility Contact</td> <td>Sister</td> </tr> <tr> <td>Father-in-Law</td> <td>Sister-in-law</td> </tr> <tr> <td>Friend</td> <td>Social Worker</td> </tr> <tr> <td>Foster Parents</td> <td>Son</td> </tr> <tr> <td>Grandchild</td> <td>Son-in-Law</td> </tr> <tr> <td>Granddaughter</td> <td>Spouse</td> </tr> <tr> <td>Grandparent</td> <td>Spouse-Separated from</td> </tr> <tr> <td>Grandson</td> <td>Teacher</td> </tr> <tr> <td>Insurance Agent</td> <td>Uncle</td> </tr> <tr> <td>Legal Guardian</td> <td>Unknown</td> </tr> <tr> <td>Mother-in-Law</td> <td></td> </tr> <tr> <td>Niece</td> <td></td> </tr> <tr> <td>Neighbor</td> <td></td> </tr> </table>	Aunt	Nephew	Brother	Other Family Members	Brother-in-Law	Other Official	Child	Parent	Daughter	Physician	Daughter-in-Law	School Contact	Ex-Spouse	Significant Other	Facility Contact	Sister	Father-in-Law	Sister-in-law	Friend	Social Worker	Foster Parents	Son	Grandchild	Son-in-Law	Granddaughter	Spouse	Grandparent	Spouse-Separated from	Grandson	Teacher	Insurance Agent	Uncle	Legal Guardian	Unknown	Mother-in-Law		Niece		Neighbor	
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Activity Type	<p>Choose the selection that best describes what the patient / client was doing at the time of the injury:</p> <p>O – Other R – Recreation T – Transport U – Unknown W – Working</p>																																				
Date of Admission	<p>Enter date you were admitted to hospital as mm/dd/yyyy (month/day/year)</p>																																				
Position	<p>Choose the selection that best describes the position of the patient / client.</p> <table border="0"> <tr> <td>1 – Driver</td><td>5 – Motorcycle Driver</td></tr> <tr> <td>10- Streetcar Occ</td><td>6 – Motorcycle Passenger</td></tr> <tr> <td>11 – Not Available</td><td>7 – Other Specified</td></tr> <tr> <td>2 – Passenger</td><td>8 – Pedal/Cyclist</td></tr> <tr> <td>4 – Pedestrian</td><td>9 – Ride Animal</td></tr> </table>	1 – Driver	5 – Motorcycle Driver	10- Streetcar Occ	6 – Motorcycle Passenger	11 – Not Available	7 – Other Specified	2 – Passenger	8 – Pedal/Cyclist	4 – Pedestrian	9 – Ride Animal																										
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