Complete this form to refer a patient directly to Concussion Service Providers when it has been determined the patient is at risk of delayed recovery based on risk factors identified.

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| 1. Client details |
| Client name:       |
| National Health Index (NHI) number:       | Date of birth:      |
| Phone number:       |
| Address:       |
| Next of kin name:        | Phone number:       |
| GP & Practice name:        | Phone number:       |

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| 2. Injury details |
| ACC45 completed: Yes [ ]  No [ ]   | ACC45 number or claim number:       |
| Early Cover (ACC7422): Yes [ ]  No [ ]  | Date of injury:       |
| Is this Concussion (or TBI): [ ]  the principal injury [ ]  an additional injury?If additional injury, please outline other injuries:     Summary of the current function and rehabilitation goals:       |
| Briefly describe how the injury occurred:       |
| Results and scores of any symptom reporting scales (eg Westmead, Rivermead, BIST, GCS, Post-Traumatic Amnesia, Clinical Frailty Scale):      |
| **Identified risk factors:**  |
| [ ]  Initial symptom burden high | [ ]  Multiple or recent concussions | [ ]  Previous protracted recovery |
| [ ]  PTA duration > 24hrs  | [ ]  Self-discharge in PTA  | [ ]  High risk job | [ ]  Female  |
| [ ]  Predominance of vestibular symptoms | [ ]  Declined intensive rehab | [ ]  Prolonged loss of consciousness | [ ]  Inadequate social situation and support |
| [ ]  Pre-existing mental health issues | [ ]  History of migraine | [ ]  < 25yrs and > 65yrs | [ ]  Alcohol and substance abuse issues |
| Other:       |

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| 3. Referral source |
| [ ]  Emergency department [ ]  Inpatient ward |
| Preferred attachments: [ ]  Discharge summary [ ]  Initial assessment [ ]  Radiology |
| Referrer details |
| Referrer name:       | Discipline:       |
| Ward or department name:       | Contact phone number:       |
| Email:       |
| Referrer signature:       | Date:       |
| Referral date from Hospital:       | Discharge date from Hospital:       |
| If you need a referral acknowledgment and acceptance, please notify: [ ]  Referrer and/or [ ]  GP |

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| 4. Select provider to send referral – Click this link [Concussion Service Provider List](https://www.acc.co.nz/for-providers/treatment-recovery/referring-to-rehabilitation/concussion-service-providers/) Please feel free to add your local area concussion service providers. |
| Provider Name:       |
| Copy in ACC using this email address: claims@acc.co.nz |

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| Concussion Service Provider onlyPlease fill in the next section after receiving the form from the referrer and send it to the Hospital and ACC |
| 5. Referral acknowledgment |
| [ ]  Referral accepted |
| [ ]  Referral declined - Reason and next steps:      [ ]  ACC to find another provider [ ]  Referrer advised |

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