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](mailto:claims@acc.co.nz) |

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| Concussion Service Provider only  Please 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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