If you’re referring a child or adolescent to the Concussion Service, fill in sections 1 to 4 of this form. Send it to your preferred Concussion Services Provider and a copy to us at: [claimsdocs@acc.co.nz](mailto:claimsdocs@acc.co.nz)

View the list of providers on [acc.co.nz](https://www.acc.co.nz/for-providers/treatment-recovery/referring-to-rehabilitation/concussion-service-providers/).

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| 1. Client details | |
| Client name: | Claim number: |
| National Health Index (NHI) number: | Date of birth: |
| Contact phone number: | Address: |
| Authorised alternative contact name: | Relationship to client: |
| Contact phone number: | Email: |

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| 2. Clinical presentation | | | | | | |
| Date of injury: | | | | Date injury reported: | | |
| How did this injury occur, ie what was the mechanism of injury? | | | | | | |
| Lowest Glasgow Coma Scale score 5-15 years: | | | | | | |
| Lowest AVPU Score (pre-school): | | ACE score: | | | | |
| Positive preschool screen:  No  Yes | | | | Positive SCAT5:  No  Yes  Not done | | |
| Which of the following symptoms were present at the time of consultation? Please tick all that apply or alternatively attach ACE, or Child SCAT5. | | | | | | |
| Loss of consciousness reported | | | Mood changes (depression, anger etc) | | | Seizures |
| Loss of balance | Fatigue | | Visual disturbances | | | Poor attention |
| Headaches | Muscular aches | | Nausea | | Dizziness | Memory problems |
| Vomiting | Restless or irritability | | Change in personality | | | Crying and inability to be consoled |
| Length of time to recover: | | | | | | |
| List any pre-existing factors or information relevant to this referral: | | | | | | |
| How many times have you or another provider (if known) seen this client for this traumatic brain injury? | | | | | | |
| Is this concussion:  the principal injury  an additional injury | | | | | | |

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| 3. Diagnosis |
| Is the diagnosis of a traumatic brain injury?  **Unconfirmed** but suspected and requiring investigation  **Confirmed** and requiringclinical management and rehabilitation  Read or ICD10 code: |

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| 4. Referrer details | |
| If this referral includes a confirmed diagnosis of concussion, we need a qualified medical professional to sign it, eg a General Practitioner (GP), Emergency Department (ED) physician or a Nurse Practitioner. We will consider emailed forms completed electronically to be signed by the doctor named in this section. | |
| Referrer name: | Medical or Nurse Practitioner  Allied health, hospital |
|  | |
| Practice or department name: | Contact phone number: |
| Postal address: | |
| Who is your preferred Concussion Service provider? Note: ACC can allocate a provider. | |
| If the referral is declined, please notify ACC and  referrer and/or  GP (name): | |
| Signature: | Date: |

In the collection, use, disclosure, and storage of information, ACC will at all times comply with the obligations of the Privacy Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982.