If you’re referring a client for a concussion service, complete sections 1 to 4 of this form and sign section 5. Email it to your preferred Concussion Services Provider and [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. Supplier details | |
| Supplier name: | Date form sent to supplier: |
| Supplier email: | Date form sent to ACC: |

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| 2. Client details | | |
| Client name: | Claim number: | |
| National Health Index (NHI) number: | Date of birth: | |
| Contact phone number: | Alternate phone number: | |
| Home address: | | |
| Was the client employed at the time of the accident?  No  Yes | | Is the client off work?  No  Yes |
| Employer contact name: | Employer phone number: | |

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| 3. Injury details | | | | | | |
| ACC45 number: | | | | Date of injury: | | |
| Date of referral: | | | | Date injury reported: | | |
| How many times have you or another provider (if known) seen this client for this injury? | | | | | | |
| Are clinical notes attached?  No  Yes | | Is this concussion:  the principal injury  an additional injury? | | | | |
| Glasgow Coma Scale score: | | | | Post-Traumatic Amnesia score: | | |
| What is your suspected or confirmed injury diagnosis? | | | | | | |
| **Suspected** injury diagnosis: | | | | | | |
| **Confirmed** injury diagnosis, including Read or ICD10 code: | | | | | | |
| Briefly describe how the injury occurred, ie the mechanism of injury: | | | | | | |
| Which of the following symptoms were present at the time of consultation? Please tick all that apply. | | | | | | |
| Loss of consciousness reported | | | Mood changes (eg depression, anger) | | | |
| Loss of balance | Fatigue | | Visual disturbances | | | Difficulty concentrating |
| Headaches | Muscular aches | | Nausea | | Dizziness | Memory problems |
| List any other symptoms that are relevant to this referral: | | | | | | |
| List any pre-existing factors that may impact recovery: | | | | | | |

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| 4. Referrer details | |
| Referrer name: | Provider number: |
| Practice or department name: | Contact phone number: |
| Postal address: | |
| If ACC does not need to allocate the provider, who is your preferred concussion service provider? | |
| If the referral is declined, please notify ACC and:  referrer and/or  GP (name): | |

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| 5. Referrer signature | |
| 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 |
| 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.