If you need to extend the concussion service for an ACC client, or you’ve completed the service, fill out this form and send it to the ACC contact person or team managing the claim. If this is not known, send to: [claimsdocs@acc.co.nz](mailto:claimsdocs@acc.co.nz).

Send the form to us within five working days of the latest service or no later than six weeks after the final service if you’re discharging the client.

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| 1. Purpose |
| What is the purpose of this client summary? Tick one. |
| End of investigation and rehabilitation planning - *Recommendation provided* |
| Interim - *Further services requested* |
| End of service – Discharge - *Update on client status at end* |

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| --- | --- |
| 2. Client details | |
| Client name: | Claim number: |
| Date of birth: | Date of injury: |

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| 3. ACC details |
| ACC contact name: |

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| --- | --- |
| 4. Provider details | |
| Provider name: | Provider number: |
| Key worker name: | Phone number: |
| Address: | Email: |

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| 5. Client’s education or employment status | | |
| What was the client’s education or employment status prior to the injury? | | |
| Child not attending school, eg pre-school or kindergarten  Child attending school: Yr 1 – Yr 13 (including home schooling)  Adult attending school or tertiary institute | | Adult not employed, including retired  Adult employed part-time  Adult employed full-time |
| School or employment details (if applicable). | | |
| School or employer name: | Phone number: | |
| Contact person: | Contact’s job title: | |
| Address: | Email: | |
| Client’s job activities (if applicable): | | |

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| 6. Diagnosis | |
| Please tick the best option. | |
| This client does **not** have a brain injury | The brain injury and symptom information provided in the Concussion service referral form is correct |
| A full medical report signed by a medical doctor is attached | The brain injury, diagnosis, and symptom information below is a clearer reflection of this client’s situation |
| Before therapy can begin, we need a diagnosis confirmed by a medical doctor. If there is no separate medical report, add the diagnosis below and have this section signed by a medical doctor. | |
| Diagnosis - include description, READ code and/or ICD10 code. Attach the medical assessment if service TBI30 was undertaken: | |
| Doctor’s name: | |
| Doctor’s signature: | Date: |

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| 7. Injury details and confirmation of symptoms | | |
| Any clinical professional can confirm symptoms. Please rate the current symptoms on a scale of 0-5, where 0 = No symptoms and 5 = High impact. | | |
| Mood changes (eg depression, anger): | Visual disturbances: | Muscular aches: |
| Memory problems: | Headaches: | Loss of balance: |
| Fatigue: | Nausea: | Dizziness: |
| Difficulty concentrating: | List other symptoms (If required): | |

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| 8. Recommendation |
| I recommend that the client: |
| 1.  be **discharged** from the concussion service as they do **NOT** have a brain injury |
| 2.  be **discharged** from the concussion service as they no longer require treatment for this brain injury |
| 3.  be **discharged** from the concussion service and receive the services recommended in section 10. |
| 4.  **remain** in the concussion service and receive the services recommended in section 9. |
| 5.  **remain** in the concussion service and receive the services recommended in sections 9. and 10. |

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| 9. Concussion services | | | | |
| If no other services are required, go to section 11. | | | | |
| Service item code | Service item description | Maximum hours for service | Quantity (hours) | Describe the issues that need resolving and actions planned to resolve them. Attach the rehabilitation plan if necessary. |
| TBI21 | Education & Assessment | 3 |  | Education, assessment, and rehabilitation has been provided. Include these services in the total cost of service. |
| TBI13 | Case Review by Neuropsychologist | Single fee |  |  |
| TBI14 | Case Review by Medical Specialist | Single fee |  |  |
| TBI22 | Allied Health Assessment | 2 |  |  |
| TBI23 | Neuropsychological screen | 5 |  |  |
| TBI30 | Medical Assessment | Single fee |  |  |
| TBI25 | Other Specialist Assessment (at cost) | 1.5 |  |  |
| TBI26 | Allied Health Therapy Sessions | 8 |  |  |
| TBI27 | Psychological Consultation | 5 |  |  |
| TBI28 | Medical Consultation | 2 |  |  |
| TBI29 | Key Worker | 4 |  |  |

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| 10. Other ACC services | |
| Use this section to recommend additional services that are not part of this contract but would benefit the client. See the concussion service operational guidelines for details. Ensure section 8 is complete. | |
| Recommended service: | Recommended service: |
| Recommended service: | Recommended service: |

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| 11. Interdisciplinary team consultation | |
| List the names of the service providers that were consulted and/or helped to complete this form. | |
| Compulsory | Optional |
| Neuropsychologist: | General practitioner: |
| Medical specialist: | Speech language therapist: |
| Occupational therapist: | Registered nurse: |
| Physiotherapist: | Other specialist(s): |

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| 12. Statement of commitment |
| If you don’t think the concussion service will benefit the client, discharge the client from the concussion service so we can engage other services if needed. |
| In accordance with the objectives of the services outlined in section 2.1 of the concussion service contract, we the suppliers, believe that, with the provision of part or all the above services, we will be able to help the client to:   * achieve their goal of returning to normal daily living, including work or school. * no longer need any further ACC services or support for this injury. |

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| 13. Discharge summary |
| Briefly describe the outcomes, goals, successes, and challenges for this client. You don’t need to repeat any information already provided. If the client is being discharged without recovery, please tick the box below and attach full clinical notes. |
| Discharge summary: |
| Discharging without recovery (full clinical notes attached) |

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| --- | --- |
| 14. Provider signature | |
| On behalf of interdisciplinary team listed in section 11. | |
| Your name: | Role: |
| Your 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.