



Health
Southern NSW
Local Health District

**SNSWLHD- Southern Area Brain
Injury Service - Referral Form**

M.R.N. _____
SURNAME: _____
OTHER NAMES: _____
D.O.B _____ SEX: _____
ADDRESS: _____
PHONE:(H) _____ (W) _____
Affix Patient ID sticker here

Date of referral:		Form Completed by:	
Client Name:		DOB:	Age:
Current Address:			
Home Ph:	Mobile Ph:	Work Ph:	
Email:			
Contact person:	Relationship:	Phone:	
Medicare No:		Country of Birth:	
Language spoken at home:		Interpreter required? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Aboriginal/Torres Strait Islander/Aboriginal & Torres Strait Islander/Non-Aboriginal (please circle one)			
Local Doctor:		Phone:	
Local Doctor Address:			
Local Doctor Email:			
Specialist 1:		Phone:	
Specialist 2:		Phone:	

REFERRAL INFORMATION

Referral Source:	
Phone:	
Address:	
Email:	
Reason for referral:	
What are the current rehabilitation needs:	
Is this person ready for rehabilitation? Yes <input type="checkbox"/>	No <input type="checkbox"/> (indicate proposed date)
Is the person aware of this referral? Yes <input type="checkbox"/>	No <input type="checkbox"/>
How did you find out about this service?	

INJURY INFORMATION

Date of injury:	
Diagnosis:	Traumatic brain injury (TBI / Non TBI (please circle one)
Circumstances of injury:	
Glasgow Coma Score at the scene: /15	Glasgow Coma Score at the ED: /15
Post Traumatic Amnesia Testing: Yes/No	Length of PTA:
<i>NB: To support eligibility for SABIS please provide any documentation that will support diagnosis of acquired brain injury ie PTA assessment forms, CT & MRI imaging results, medical and allied health discharge summaries</i>	

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Current Functional Status (cognitive, physical, psychological):

 Other relevant medical information/ co-morbidities:

 Current medication:

PAEDIATRICS

PAEDIATRIC CLIENTS: Have you discussed this referral with the family? YES NO
 School: _____ Year level: _____
 School contact: _____ Phone: _____

RISK SCREEN (tick as appropriate)

History of aggression/violence/inappropriate behavior YES NO
 Risk of self-harm. YES NO
 Known substance use (inc tobacco) YES NO
 Domestic Safety Issues YES NO
 Presence of other persons who may pose a risk YES NO
 Dangerous animals on premises YES NO
 Environmental/Access risk – entry, lighting, hygiene YES NO
 Firearms on the premises YES NO
 Other: _____

OCCUPATIONAL INFORMATION

Unemployed / Employed or studying / Job held open / Terminated / /
 Occupation _____ Employer / School _____

INSURER INFORMATION

LTCS / CTP / Workcover / Victim Compensation / Comcare / Unknown / Not applicable / BIS Pending
 Insurer _____ Claim No. _____
 Insurer address _____
 Contact person _____ Phone _____ Fax _____
 Status – Liability accepted / Liability denied / Pay without prejudice / Unknown
 Solicitor _____ Phone _____ Fax _____
 Solicitor address _____

NDIS INFORMATION

Are you a NDIS participant: YES NO
 If yes, Name of Support Co-ordinator: _____
 Services / Agencies involved: _____
 Referral taken by: _____
 Office Use Only:
 Does referral fit eligibility criteria? Yes No More Information Needed
 CM Allocated: _____
 If not, what alternative services were suggested?

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Pg.2. **Return referral form to:**

Southern Area Brain Injury Service
 Locked Bag 2015, Goulburn NSW 2580
 Fax: - 02 4825 4921 or email SNSWLHD-SABIS@health.nsw.gov.au
 Please contact SABIS on 02 4825 4911 if you have any queries.

Current	Past