**BRAIN DISORDERS PROGRAM COMMUNITY SERVICES REFERRAL FORM**

 **1. SERVICE:** CBDATS: [ ]

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|  **DATE:**  |        |

**2. CLIENT DETAILS** |
| SURNAME:       | GIVEN NAMES:        | TITLE:        |
|  |  |  |  |
| DATE OF BIRTH:       | RAPID UR:        | AUSTIN UR:        |
|  |  |  |  |
| ADDRESS:        | Pcode:      | Withheld: [ ]  |
|  |  |
| PHONE: (H):       (M):        | Silent:[ ]  | SEX: Male: [ ]  Female: [ ]  Other: [ ]  |
|  |
| COUNTRY OF BIRTH:       | ABORIGINAL: [ ]  TSI: [ ]  Neither: [ ]  | MARITAL STATUS:        |
|  |
| PREFERRED LANGUAGE:       | INTERPRETER REQUIRED: Yes: [ ]  No: [ ]  | RELIGION:       |
|  |
| ACCOM TYPE: Supported:[ ]  Aged Care:[ ]  Alone:[ ]  Family:[ ]  Other:       |
|  |
| MEDICARE NO: |       Card Position Ref       |
|  |
| COMPENSABLE: | TAC: [ ]  Workcover: [ ]  Other:       |
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| NDIS STATUS: | Participant No:       Plan Date:       Support Co-ord:        |
|  |
| HEALTH FUND:       | LEVEL OF HEALTH FUND:       |
| **3. REFERRAL SOURCE** |
| NAME:       | AGENCY:       |
| ADDRESS:       |
| PHONE: W):       (M):       EMAIL ADDRESS:       |
| **4. MEDICAL TREATMENT DECISION MAKER (MTDM)** e.g. spouse, parent, appointed MTDM, guardian  (attach documentation for appointed MTDM, guardian, nominated person, MTDM support person) |
| NAME:       | RELATIONSHIP:       |
| ADDRESS:       |
| PHONE: W):       (M):       EMAIL ADDRESS:       |
| **5. ACQUIRED BRAIN INJURY (ABI)**  |
| TYPE: Traumatic: [ ]  Hypoxic: [ ]  Substance related (*includes alcohol*): [ ]  Stroke: [ ]  Neurodegenerative: [ ]  Tumour: [ ]  Other:       |
| DETAILS: **How** and **when** did the brain injury occur? *Provide severity indicators as appropriate (e.g. PTA, downtime etc )*      |
| **6. GP AND OTHERS INVOLVED** *(****please include private psychiatrists****)* |
| GENERAL PRACTITIONER NAME:        | PHONE:        | FAX:        |
| CLINIC NAME AND ADDRESS:        |
| NAME:        | AGENCY:         | PHONE:       |
| NAME:        | AGENCY:        | PHONE:       |
| FAMILY CONTACT :        | RELATIONSHIP:        | PHONE:       |

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| **7. PRESENTING PROBLEM/S**(*Please describe the problems in your own words, including symptoms, onset, stressors etc*) |
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| **8. BEHAVIOUR***Please indicate whether or not the following behaviours are present. Where behaviours have been indicated as present, please provide examples. Please note that a lack of detail may result in some delay in processing this referral.*  |
| **BEHAVIOUR** | **PRESENT** | **EXAMPLES** |
| Verbal aggression | Yes: [ ]   |       |
| Physical aggression | Yes: [ ]   |       |
| Social disinhibition | Yes: [ ]   |       |
| Perseveration *(repetitive behaviours)* | Yes: [ ]   |       |
| Reduced initiation  | Yes: [ ]   |       |
| Sexually disinhibition | Yes: [ ]   |       |
| Wandering/absconding | Yes: [ ]   |       |
| Other:       |
| **9. PSYCHIATRIC HISTORY** |
|       |
| **10. MEDICAL HISTORY** |  **11. CURRENT MEDICATIONS** |
|       |       |

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| **12. CBDATS OR ABI BEHAVIOUR CONSULTANCY SERVICE INVOLVEMENT***What would you like this service to do? Why make a referral now?* |
|       |
| **13. SUPPORTING DOCUMENTATION***Please attach all relevant supporting documentation (please note referrals cannot be processed until sufficient documentation is received).* |
| **Neuropsychological reports:** Attached: [ ] To follow: [ ] Why unavailable?:       |
| **Medical/psychiatric reports:** Attached: [ ] To follow: [ ] Why unavailable?:       |
| **Other (e.g. NDIS Plan):**         |