

BRAIN DISORDERS PROGRAM COMMUNITY SERVICES REFERRAL FORM

1. **SERVICE:** ABI Behaviour Consultancy: CBDATS:

2. CLIENT DETAILS

DATE:

SURNAME:		GIVEN NAMES:		TITLE:
DATE OF BIRTH:		RAPID UR:	AUSTIN UR:	
ADDRESS:			Pcode:	Withheld: <input type="checkbox"/>
PHONE: (H):	(M):	Silent: <input type="checkbox"/>	SEX: Male: <input type="checkbox"/> Female: <input type="checkbox"/> Other: <input type="checkbox"/>	
COUNTRY OF BIRTH:		ABORIGINAL: <input type="checkbox"/> TSI: <input type="checkbox"/> Neither: <input type="checkbox"/>	MARITAL STATUS:	
PREFERRED LANGUAGE:		INTERPRETER REQUIRED: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	RELIGION:	
ACCOM TYPE: Supported: <input type="checkbox"/> Aged Care: <input type="checkbox"/> Alone: <input type="checkbox"/> Family: <input type="checkbox"/> Other:				
MEDICARE NO:		Card Position Ref		
COMPENSABLE: TAC: <input type="checkbox"/> Workcover: <input type="checkbox"/> Other:				
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: <input type="checkbox"/> Hypoxic: <input type="checkbox"/> Substance related (includes alcohol): <input type="checkbox"/> Stroke: <input type="checkbox"/> Neurodegenerative: <input type="checkbox"/> Tumour: <input type="checkbox"/> 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:

7. PRESENTING PROBLEM/S

(Please describe the problems in your own words, including symptoms, onset, stressors etc)

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: <input type="checkbox"/>	
Physical aggression	Yes: <input type="checkbox"/>	
Social disinhibition	Yes: <input type="checkbox"/>	
Perseveration <i>(repetitive behaviours)</i>	Yes: <input type="checkbox"/>	
Reduced initiation	Yes: <input type="checkbox"/>	
Sexually disinhibition	Yes: <input type="checkbox"/>	
Wandering/absconding	Yes: <input type="checkbox"/>	
Other:		

9. PSYCHIATRIC HISTORY

10. MEDICAL HISTORY

11. CURRENT MEDICATIONS

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12. CBDATS OR ABI BEHAVIOUR CONSULTANCY SERVICE INVOLVEMENT

Why make a referral now? What would you like this service to do?

13. SUPPORTING DOCUMENTATION

Please attach all relevant supporting documentation (please note referrals cannot be processed until sufficient documentation is received).

Neuropsychological reports: Attached: <input type="checkbox"/> To follow: <input type="checkbox"/> Why unavailable?:
Medical/psychiatric reports: Attached: <input type="checkbox"/> To follow: <input type="checkbox"/> Why unavailable?:
Other (e.g. NDIS Plan):

