**BRAIN DISORDERS PROGRAM COMMUNITY SERVICES REFERRAL FORM**

**1. SERVICE:** CBDATS:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **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: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| 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?* |
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| **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):** |