Please fax to (03) 9490 7358 or
email to bdpv@austin.org.au

BRAIN DISORDERS PROGRAM COMMUNITY SERVICES REFERRAL FORM

1. SERVICE: CBDATS: ☐

2. CLIENT DETAILS **DATE:**

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: CLINIC NAME AND ADDRESS:	PHONE:	FAX:
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: ☐	
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

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):