

Only General Practitioners or DHB Emergency Department staff can complete this form to refer a client to Concussion Services. For more information about how to complete this form, please refer to the guide.

PART ONE: REFERRER TO COMPLETE AND SEND TO ACC**1. CLIENT DETAILS**

Client name:	
Date of birth:	NHI number:
Home phone number:	Work phone number:
Address:	
Employed? <input type="checkbox"/> No <input type="checkbox"/> Yes – please state employer name:	

2. INJURY INFORMATION

ACC45 number:	Date of injury:	
Date of injury reported:	Date of consultation:	
Number of times the client has been seen for this TBI injury:		
Injury type: <input type="checkbox"/> Principal injury <input type="checkbox"/> Additional injury	GCS:	PTA:
Injury diagnosis:		
Mechanism of injury:		
Symptoms present at consultation time: <input type="checkbox"/> Loss of consciousness reported <input type="checkbox"/> Loss of balance <input type="checkbox"/> Mood changes (depression etc) <input type="checkbox"/> Headaches <input type="checkbox"/> Memory problems <input type="checkbox"/> Visual disturbances <input type="checkbox"/> Fatigue <input type="checkbox"/> Nausea <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Muscular aches		
Description of symptoms (if required):		
Pre-existing factors that may impact recovery (if applicable):		

3. REFERRER DETAILS

Referrer name:	Provider number:
Phone number:	Fax number:
Address:	
Preferred Concussion Service provider: Focus on Potential Ltd – Concussion Services	
If services are declined, please notify: <input type="checkbox"/> Referrer <input type="checkbox"/> Other service provider – please state name:	
Signature:	Date:

PART TWO: ACC TO COMPLETE AND FAX TO APPROVED VENDOR WITH PART ONE

4. FUNDING DECISION

NOTE: TBI21 service maximum is 3 Hours

Decision: ☐ Funding approved (TBI21 education, Assessment and Rehabilitation Planning)
☐ Funding declined – please state reason:

Complete the following fields if funding is approved

Approved vendor: Focus on Potential Ltd Concussion Services	Vendor number: FOCUPOTE
Claim number:	Purchase order number:
Signature	
Client Service staff member:	Phone number:
Signature:	Date:
ACC branch address:	
Fax number:	Date form sent:

The information collected on this form will only be used to fulfil the requirements of the Accident Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.