Health
Northern NSW
Local Health District

PATIENT LABEL

NORTHERN BRAIN INJURY REHABILITATION SERVICE

REFERRAL FORM

CLIENT INFORMATION

Title:	Name:	DOB:	Gender:
Current Address:			
Home Ph:	Mobile Ph:	Work Ph:	
Email:			
Contact person:	Relationship:	Phone:	
Medicare No:	Country of birth: Australia	Language:	
Aboriginal/ Torres Strait Islander/ Aboriginal & Torres Strait Islander/ Non-Aboriginal *(circle one)*			
Next Of Kin/Legal Guardian			
Local Doctor:	Ph:	Fax:	
Local Doctor Address:			
Specialist 1:	Ph:	Fax:	
Specialist 2:	Ph:	Fax:	

NBIRS ELIGIBILITY CRITERIA

1. Documented traumatic brain injury or complex acquired brain injury	
Diagnosis / type of injury:	
Is there documented evidence of the injury? *(MRI, CT, acute discharge summary):* Yes ☐ No ☐	
Date of injury:	Glasgow Coma Score: /15 When/Where Measured:
Post Traumatic Amnesia Length:	When/Where Measured:
Current Functional Status: *Describe cognitive, physical, communication, & psychosocial function.*	
Other relevant medical information/ co-morbidities:	
2. Realistic and achievable rehabilitation goals	
Does the person have realistic and achievable rehabilitation goals that can be addressed in the community? NB: These must be client-generated goals. Yes ☐ No ☐	
Comments:	
What are the person's rehabilitation goals?	
1.	
2.	
3.	
4.	
5.	
Other comments:	

3. Motivation and/or capacity to participate in rehabilitation
Does the person have the motivation and capacity to participate in community-based rehabilitation? *NB: Clients with acute mental health conditions, or who are excessively consuming drugs or alcohol may not be eligible.* Yes ☐ No ☐
Comments:

REFERRAL INFORMATION

Date of referral:
Referrer:
Phone:
Address:
Email:

RISK SCREEN *(comment where applicable)*

Yes	No	
❑	❑	History of aggression
❑	❑	History of violence
❑	❑	History of inappropriate behaviours
❑	❑	Risk of self-harm
❑	❑	Vulnerability (e.g. financial, emotional exploitation etc)
❑	❑	Known substance use (incl tobacco)
❑	❑	Domestic safety issues
❑	❑	Presence of other persons who may pose a risk
❑	❑	Dangerous animals on premises
❑	❑	Environmental/Access risk – entry, lighting, personal hygiene

OCCUPATIONAL INFORMATION

Employed: Yes / No	Occupation:
Employer / School:	Other:

ADDITIONAL INFORMATION *(if known)*

LTCS / CTP / WorkCover / NDIS / Unknown / Not applicable/ Status Pending *(please circle one)*		
Insurer :	Claim No.:	
Insurer address:		
Contact person :	Phone:	Fax:
Email:		
Status		

CHECKLIST FOR REFERRER BEFORE SENDING

Referral discussed with patient: Yes / No	Reason not discussed:
Relevant Reports attached? ❑ Discharge Summaries ❑ PTA score sheet ❑ Other injury-related reports (e.g. neuro-imaging, allied health).	

Return Completed Referral Form to:

NBIRS – Ballina District Hospital, PO Box 523, Ballina NSW 2478

Phone 02 6620 6361 Email NNSWLHD-NBIRS@health.nsw.gov.au Fax 02 6620 6348