Complete this form to refer a client for a concussion service.

Email it directly to a Concussion services supplier and to ACC at [claimsdocs@acc.co.nz](mailto:claimsdocs@acc.co.nz).

View the list of Concussion services suppliers on [acc.co.nz](https://www.acc.co.nz/for-providers/treatment-recovery/referring-to-rehabilitation/concussion-service-providers/).

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| 1. Concussion service supplier details | |
| Supplier: **Coastal Rehab Services Ltd**  Email to: [**admin@coastalrehabservices.co.nz**](mailto:admin@coastalrehabservices.co.nz)  **ACC Vendor G07858** | Date of referral: |

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| 2. Client details | | | |
| Name: | | Date of birth: | |
| National Health Index (NHI) number: | | Contact phone number: | |
| Home address: | | | |
| Contact person name: | Relationship: | | |
| Was the client employed at the time of the accident? | | | Yes  No | |
| Is the client off work or school? | | | Yes  No | |
| Occupation and employer or school name (if known): | | | | |

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| 3. Injury details | | | | |
| ACC claim number: | | | Date of injury: | |
| Supplementary information provided: | | | | |
| Brain Injury Screening Tool (BIST) | Clinical notes | ACC45 | | Other |
| What is your suspected or confirmed injury diagnosis? | | | | |
| **Suspected** injury diagnosis: | | | | |
| **Confirmed** injury diagnosis, including Read or ICD10 code: | | | | |
| Briefly describe how the injury occurred (mechanism of injury): | | | | |

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| **4. Risk factors associated with delayed recovery** | |
| Concussion services are for clients identified as being at risk of delayed recovery from their injury. Please complete both sections below. |
| List factors indicating the client is at risk of delayed recovery from their injury (optional if BIST information is attached): | |
| List any other conditions or pre-existing factors that may affect the client’s recovery from their injury. | |

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| 5. Referrer details | | |
| Referrer name: | | Contact phone number: |
| Practice name: | | Email: |
| For suppliers, if the referral is declined, please notify ACC and:  Referrer and/or  GP (provide GP’s name): | | |
| I declare the information provided on this form is, to the best of my knowledge, accurate and complete. | | |
| Signature: | Date: | |

In the collection, use, disclosure, and storage of information, ACC will at all times comply with the obligations of the Privacy Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982.