Referral form

1. Client details
   Client name:
   Client ID number:
   Date of birth:
   Work phone number:
   Home phone number:
   Address:
   Was the client employed at the time of the accident? no yes
   ls the client off work? No yes
   Employer contact name:
   Employer phone number:
2. lnjury details
   Insurance company:
   Date of injury:
   Date of referral:
   Date injury reported:
   How many times have you or another provider (if known) seen this client for this traumatic brain injury?
   Are clinical notes attached? No Yes
   ls this concussion: the principal injury an additional injury?
   Glasgow Coma Scale score:
   Post-Traumatic Amnesia score:
   What is your suspected or confirmed injury diagnosis?
   Suspected injury diagnosis:
   Confirmed injury diagnosis, including Read or lCD10 code:

   Briefly describe how the injury occurred, eg the mechanism of injury: Which of the following symptoms were present at the time of consultation? Please tick all that apply.
   Loss of consciousness reported Mood changes (depression, anger etc)
   Loss of balance Fatigue visual disturbances
   Difficulty concentrating Headaches Muscular aches
   Nausea Dizziness Memory problems
   List any other symptoms that are relevant to this referral:

   List any pre-existing factors that may impact recovery: