

Concussion Service child or adolescent referral

Complete this form to refer a child or adolescent to the Concussion Service. We'll use the information gathered here to make sure the child or adolescent (aged of 0-15) receives the appropriate assistance from ACC. We'll forward the referral to the service supplier within two business days.

Please return this form along with all relevant clinical notes to your nearest ACC Short Term Claims Centre:

- Wellington STCC: WSTCCACC883@acc.co.nz
- Northern STCC: Stcc-n@acc.co.nz
- Northern South Island STCC: STCC-NS@acc.co.nz
- Southern STCC: ScriptsDCC@acc.co.nz.

1. Client details			
Client name:		Claim number:	
National Health Index (NHI) number:		Date of birth:	
Home phone number:		Address:	
Authorised client alternative contact name:		Relationship to client:	
Contact phone number:		Email address:	

2. Clinical presentation			
Date of injury:		Date injury reported:	
How did this injury occur, ie what was the mechanism of injury?			
Lowest Glasgow Coma Scale score 5-15 years:			
Lowest AVPU Score (pre-school):		ACE score:	
Positive preschool screen: <input type="checkbox"/> No <input type="checkbox"/> Yes		Positive SCAT3: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not done	
Which of the following symptoms were present at the time of consultation? Please tick all that apply or alternatively attach ACE, Child SCAT3 or SCAT 3 assessment.			
<input type="checkbox"/> Loss of consciousness reported	<input type="checkbox"/> Mood changes (depression, anger etc)	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Visual disturbances	<input type="checkbox"/> Poor attention
<input type="checkbox"/> Headaches	<input type="checkbox"/> Muscular aches	<input type="checkbox"/> Nausea	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Restless or irritability	<input type="checkbox"/> Change in personality	<input type="checkbox"/> Crying and inability to be consoled
Length of time to recover:			
List any pre-existing factors or information relevant to this referral:			
How many times have you or another provider (if known) seen this client for this traumatic brain injury?			
Is this concussion: <input type="checkbox"/> the principal injury <input type="checkbox"/> an additional injury			

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3. Diagnosis

Is the diagnosis of a traumatic brain injury?

☐ **Unconfirmed** but suspected and requiring investigation

☐ **Confirmed** and requiring clinical management and rehabilitation

Read or ICD10 code:

4. Referrer details

To refer this client you must be a medical professional or be working on the instruction of a medical professional. Please make sure the referring doctor is named.

If this referral is confirming or adding a diagnosis of concussion a qualified medical professional must sign this section. We will consider emailed forms completed electronically to be signed by the doctor named in this section.

Referring Doctor name:

Who is ☐ DHB medical staff ☐ GP

This referral has been completed by: ☐ Doctor above ☐ DHB Allied Health Staff (clinical notes included)

Practice or department name:

Contact phone number:

Postal address:

Who is your preferred Concussion Service provider? Note: ACC can allocate a provider.

If services are declined, please notify ☐ referrer and/or ☐ GP (name):

Signature:

Date:

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.