



Concussion service referral

If you've got a patient that you're referring for a concussion service, please fill out sections 1 to 4 of this form and send it to your nearest ACC Short Term Claims Centre so we can approve the referral before the service begins:

- Wellington STCC: WSTCCACC883@acc.co.nz
- Northern STCC: Stcc-n@acc.co.nz Fax: 0800 222 890
- 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:
Work phone number:	Home phone number:
Address:	
Was the client employed at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes Is the client off work? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Employer contact name:	Employer phone number:

2. Injury details

ACC45 number or claim number:	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? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is this concussion: <input type="checkbox"/> the principal injury <input type="checkbox"/> an additional injury?
Glasgow Coma Scale score:	Post-Traumatic Amnesia score:
What is your suspected or confirmed injury diagnosis?	
<input type="checkbox"/> Suspected injury diagnosis:	
<input type="checkbox"/> Confirmed injury diagnosis, including Read or ICD10 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.	
<input type="checkbox"/> Loss of consciousness reported	<input type="checkbox"/> Mood changes (depression, anger etc)
<input type="checkbox"/> Loss of balance <input type="checkbox"/> Fatigue	<input type="checkbox"/> Visual disturbances <input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Headaches <input type="checkbox"/> Muscular aches	<input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness <input type="checkbox"/> Memory problems
List any other symptoms that are relevant to this referral:	
List any pre-existing factors that may impact recovery:	

ACC883 Concussion service referral

3. Referrer details	
Referrer name:	Provider number:
Practice or department name:	Contact phone number:
Postal address:	
If ACC does not need to allocate the provider, who is your preferred concussion service provider?	
Focus on Potential	
If services are declined, please notify: <input type="checkbox"/> referrer and/or <input type="checkbox"/> GP (name):	
4. Referrer signature	
If this referral includes a confirmed diagnosis of concussion, we need a qualified medical professional to sign it, eg a General Practitioner (GP) or Emergency Department (ED) physician. We will consider emailed forms completed electronically to be signed by the doctor named in this section.	
Referrer name:	<input type="checkbox"/> Medical (ED, GP) <input type="checkbox"/> Allied health, hospital
Signature:	Date:
ACC staff fill out these next sections after receiving the form from the referrer.	
5. Funding decision [ACC only]	
Note: TBI21 service maximum is 3 hours.	
Funding approved:	<input type="checkbox"/> Funding declined
<input type="checkbox"/> TBI21 Investigation, risk assessment and symptom education	Reason:
<input type="checkbox"/> TBI23 Neuropsychological screen to investigate diagnosis	
<input type="checkbox"/> TBI24 Medical specialist (to investigate diagnosis)	
Only fill out this section if funding is approved.	
Approved supplier:	Supplier number:
Claim number:	Purchase order number:
6. ACC details and signature [ACC only]	
ACC office:	Date form sent to supplier:
Name:	Contact phone number:
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.