Health
Southern NSW
Local Health District

SNSWLHD- Southern Area Brain Injury Service - Referral Form

M.R.N.
SURNAME:
OTHER NAMES:
D.O.B SEX:
ADDRESS:
PHONE:(H) (W)
Affix Patient ID sticker here

SABIS REFERRAL FORM

Date of referral:	Form Completed by:	
Client Name:	DOB:	Age:
Current Address:		
Home Ph:	Mobile Ph:	Work Ph:
Email:		
Contact person:	Relationship:	Phone:
Medicare No:	Country of Birth:	
Language spoken at home:	Interpreter required? ☐ YES ☐ NO	
Aboriginal/Torres Strait Islander/Aboriginal & Torres Strait Islander/Non-Aboriginal (please circle one)		
Local Doctor:	Phone:	
Local Doctor Address:		
Local Doctor Email:		
Specialist 1:	Phone:	
Specialist 2:	Phone:	

REFERRAL INFORMATION

Referral Source:		
Phone:		
Address:		
Email:		
Reason for referral:		
What are the current rehabilitation needs:		
Is this person ready for rehabilitation? Yes ☐	No ☐ (indicate proposed date)	
Is the person aware of this referral? Yes ☐	No ☐	
How did you find out about this service?		

INJURY INFORMATION

Date of injury:	
Diagnosis:	Traumatic brain injury (TBI / Non TBI (please circle one)
Circumstances of injury:	
Glasgow Coma Score at the scene: /15	Glasgow Coma Score at the ED: /15
Post Traumatic Amnesia Testing: Yes/No	Length of PTA:

NB: To support eligibility for SABIS please provide any documentation that will support diagnosis of acquired brain injury ie PTA assessment forms, CT & MRI imaging results, medical and allied health discharge summaries

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SABIS REFERRAL FORM

Current Functional Status (cognitive, physical, psychological):
Other relevant medical information/ co-morbidities:
Current medication:

PAEDIATRICS

PAEDIATRIC CLIENTS: Have you discussed this referral with the family? ☐ YES ☐ NO	
School:	Year level:
School contact:	Phone:

RISK SCREEN (tick as appropriate)

History of aggression/violence/inappropriate behavior	YES ☐ NO ☐
Risk of self-harm.	YES ☐ NO ☐
Known substance use (inc tobacco)	YES ☐ NO ☐
Domestic Safety Issues	YES ☐ NO ☐
Presence of other persons who may pose a risk	YES ☐ NO ☐
Dangerous animals on premises	YES ☐ NO ☐
Environmental/Access risk – entry, lighting, hygiene	YES ☐ NO ☐
Firearms on the premises	YES ☐ NO ☐
Other:	

OCCUPATIONAL INFORMATION

Unemployed / Employed or studying / Job held open / Terminated / /	
Occupation	Employer / School

INSURER INFORMATION

LTCS / CTP / Workcover / Victim Compensation / Comcare / Unknown / Not applicable / BIS Pending		
Insurer	Claim No.	
Insurer address		
Contact person	Phone	Fax
Status – Liability accepted / Liability denied / Pay without prejudice / Unknown		
Solicitor	Phone	Fax
Solicitor address		

NDIS INFORMATION

Are you a NDIS participant: **YES** ☐ **NO** ☐	
If yes, Name of Support Co-ordinator:	
Services / Agencies involved:	
Referral taken by:	
Office Use Only: Does referral fit eligibility criteria? ☐ Yes ☐ No ☐ More Information Needed	
CM Allocated:	
If not, what alternative services were suggested?	

Return referral form to:
Southern Area Brain Injury Service
Locked Bag 2015, Goulburn NSW 2580
Fax: - 02 4825 4921 or email SNSWLHD-SABIS@health.nsw.gov.au
Please contact SABIS on 02 4825 4911 if you have any queries.

Current	Past