Acquired Brain Injury Program Referral

To the Referrer,

IPC Health provides a short term (approximately 6 months) Case Management service for people with an Acquired Brain Injury (ABI).

The waitlist for the ABI program is relatively short, generally a few months.

Please note: the ABI Case Management program does not provide a service to take people to appointments or funding.
We can take people to an appointment if there is a reason to for the Case Manager to attend but we are not a transport service. We can put in applications for funding if it is necessary but there is no guarantee we will be successful.

When referring to this service comprehensive information to determine eligibility, priority and equity of access is required.

Priority will be given to people who:

- identify as Aboriginal or Torres Strait Islander
- have no support from family, friends or other professionals
- have Carer Burnout or Carer Required
- live in insecure or inappropriate housing
- live in more isolated areas lacking transport or alternative services
- have significant impact due to having cognitive impairment
- have special needs due to cultural and linguistic diversity
- are unable to have their needs met through other existing programs.

Required Information / Documentation

- Comprehensive completion of all questions on the referral form
- Signed consent by the client or their representative
- Evidence of an ABI i.e. Neuropsychological Report, detailed GP letter, discharge summary including cause and effects of injury.

Prospective clients need to be informed that the receipt of the referral is only the first part of the process. It will be screened to determine appropriateness for Case Management. It is also advisable to inform the
prospective client that if the referral is accepted they will be placed on the waiting list for allocation of a Case Manager.

Thank you for assisting us in making this process as streamlined as possible.

Yours sincerely,

Lynne Smith - ABI Intake

Please send completed application and signed consent form to Lynne.smith@ipchealth.com.au or Fax Attention Lynne Smith ABI program 9366 2086 with evidence of ABI.

If any concerns please ring Lynne Smith 9296 1347 or 0417202461

(Note: Do not send these pages back)

Acquired Brain Injury Program

Case Management Referral Form

Date of Referral:_____

ABI ☐ Linkages ☐

Personal Information:

Name: _____ :Date of Birth:_____

Address: _____

Post Code:_____ Municipality _____

Home Phone Number: _____ Mobile Number: _____

Gender: _____ Sexual Identity _____

Country of Birth: _____ Culture_____

Religion _____ Spirituality_____

Residence: Private Rental ☐ Public Housing ☐ Owned/Purchasing Home ☐ SRS ☐

Nursing Home ☐ Boarding House ☐ Is Homeless ☐

Other ☐ Please explain: _____

Living Situation :

Live Alone ☐ Live with Family ☐ Lives with Others ☐ Please Explain:_____

_____

Language:

Preferred language:_____ Interpreter required: _____

Method of communication: Spoken Language ☐ Sign Language ☐ Other Effective non

Verbal Communication ☐ Little Or No Effective Communication ☐

Indigenous Status:

Aboriginal ☐ Torres Strait Islander ☐ Neither ☐

Source of income:

Disability Support Pension ☐ Income Protection ☐ Compensation Payments ☐

Newstart Allowance ☐ Working ☐ Other ☐

_____

Disabiltiy / ABI Information:

Primary Disability: _____

Date of ABI / Date known of Disability:_____ Birth ☐

Cause of Injury/ Disability:_____

_____

_____

_____

_____

_____

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_____

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Effects: (Please do not write see report)

_____

_____

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_____

_____

_____

_____

Other Disabilities – not related to the original Disability / ABI:_____
_____
_____
_____
_____

Please note: There must supporting documentations that stated this person has the disability that you have outlined and that it is going to be permenant and preferably what the effects are.

Powers Of Attorney / Guardianship:

Is there a financial Power of Attourney or a Guardian in place? If so please supply the details

Financial Power of attorney ☐ Details of person Managing -
_____

Guardian ☐ Details of person Managing
_____

Emergency Contacts:

Name:_____ Contact number _____

Address: _____

Relationship: _____ :

Name:_____ Contact number _____

Address: _____

Relationship: _____

Carer Information:

Carer name: _____ Carer Relationship: _____ Carer Age:_____

Does the carer live with the client: ☐ Yes ☐ No

Does the carer assist with self care, mobility or communication: ☐ Yes ☐ No

Does the carer receive a service from Psychiatric Disability Support Services: ☐ Yes ☐ No

Referrer Information:

Referrer: _____ Contact Number:_____

Organisation (if applicable):_____

Address: _____

Email:_____

Is this person on any other Case Management waitlist? Please give details: _____
_____
_____
_____

Is the person receiving any funding or compensation(TAC, ISP, ACL, etc)? Please give details:

_____
_____
_____
_____

Medical Support Services:

Name of GP:_____ Phone:_____

Medical Centre_____

Medicare card number: _____

Health Care Card number: _____

Medication Management:

Self ☐ RDNS ☐ Dosette Box ☐ Webster ☐

Please list current medication: (Please do not write see report) _____

_____

_____

_____

_____

_____

Current Medical Details:

☐ Allergies
☐ Dental
☐ Speech
☐ Respiratory problems
☐ Diabetes
☐ Seizures
☐ Vision
☐ Gastrointestinal problems
☐ Chronic pain
☐ Liver disease
☐ Hearing
☐ Cardiac problems
☐ Skeletal injuries

Other:_____

_____

_____

_____

_____

Current Services

Service Provider	Contact Details	Type of Services	Day/s	Time	Frequncy

Recommended Services

Service Provider	Contact Details	Type of Services	Day/s	Time	Frequncy

Personal Hygiene:

Preferences: Shower ☐ Wash ☐ Bath ☐

Independent ☐ With Supervision ☐ With Assistance ☐

Frequency: Days _____ Times: _____

Bathroom Equipment: Rails ☐ Shower chair ☐ Bath Seat ☐ Swivel ☐

Hand Held Shower ☐ Hoist ☐

Is there any other important information in relation to personal hygiene: _____

_____

Toileting:

Independent ☐ With Assistance ☐ Dependent ☐

Is the person able to able to express their need to use the toilet? Yes ☐ No ☐

Equipment: Rails ☐ Raised Toilet Seat ☐ Over Toilet Comode Chair ☐

Comode ☐ Urinal ☐ Hoist ☐

If the person needs support with toiletting what is required? _____

_____

Vision, Hearing and Speech:

Hearing (comments):_____

_____

_____

Hearing Aids Yes ☐ No ☐

Has hearing been tested Yes ☐ No ☐ Not required ☐

Vision (comments):_____

_____

_____

Vision Aids Yes ☐ No ☐ if yes please explain _____

Has vision tested Yes ☐ No ☐ Not required ☐

Speech (comments):_____
_____
_____

Speech Aids Yes ☐ No ☐ (if yes please explain) _____
Health Aids (includes _____
_____

Please provide details on any Mental Illness: (Please do not write see report) _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Behaviours:

☐ Self harm	☐ Impulsive	☐ Passive
☐ Wandering	☐ Discruptive	☐ Inactive
☐ Physical aggression	☐ Verbally aggressive	☐ Verbose
☐ Egocentric	☐ Screaming	☐ Irritable
☐ Perseverates	☐ Agitated	☐ Sexually inappropriate
☐ Disinhibited	☐ Labile	

If any of these occur or any other behaviours are displayed please give details: (Please do not write see report)

_____
_____
_____
_____
_____
_____
_____
_____

Personal History:

Life Changes:_____

Education/ Occupation:_____

Interests:_____

Alcohol or Other Drug Use Past And or Present: (Please do not write see report) _____

Details of Current or Previous Criminal History: (Please do not write see report) _____

Concession Cards:

Does the person have the following:

☐ Companion Card ☐ Multipurpose Taxi Card

☐ Disability Parking Permit

Degree of Participation:

To what extent does the person participate in the following life areas?					
N.B. *Please tick only one box for each area*	Fully	Partially	Not At All	Unknown	N/A
Getting around outside					
Using transport					
Maintaining relationships with family					
Maintaining social relationships					
Recreation or leisure activities					
Working					
Handling money					

How often does the person need personal help or supervision to participate in the following areas?					
N.B. *Please tick only one box for each area*	Always	Sometimes	Uses aid/ equipment	No help/ aids needed	N/A
Self Care					
Mobility					
Communication					
Interpersonal interactions and relationships					
Learning, applying knowledge and general tasks and demands					
Education					
Community and Economic life					
Domestic life					
Working					

Risks For Home Visit:

What Risks are there for staff undertaking a Home Visit (e.g. dog in house, weapons, obstructions, or from other people that may be present)?

How Does This Person's ABI or Disability Impact on Their Current Circumstances?

Reason For Referral:

Why have you referred this person to our service (please be very descriptive and do not provide one word responses as these are not helpful and we often don't know what you mean).
Please list 3 ABI / Disability related goals you feel our service can assist with:

1._____
_____
_____
_____
_____

2._____
_____
_____
_____
_____

3._____
_____
_____
_____
_____

Consent:

By completing this form it is understood that consent for referral has been obtained	
The person consents to IPC Health Acquired Brain Injury Program contacting the referrer and other agencies that are either providing a service to them (or have also received a referral for Case Management) and /or significant people (such as emergency contacts listed in this form). Furthermore, they also consent to IPC Health in providing non-identifying statistical data to funding bodies.	
Signature of person referred or guardian: (Not service provider)	Date: