REFERRAL / INTAKE FORM

PERSONAL DETAILS

REFERRAL DATE:

First Name
Gender M F
Last Name
Date of Birth

ADDRESS DETAILS

Home Address
Residence
- Private Household
- Group Home
- Residential Facility
- Other

Home Phone
Work Phone
Mobile Phone
Email

WHAKAPAPA

Ethnicity
Iwi
Hapu

DOCTOR

Doctor
Clinic
Phone

WHANAU & SUPPORTS

Name	Phone	Next of Kin ☐
Name	Phone	Next of Kin ☐
Name	Phone	Next of Kin ☐

Comments

REFERRAL DETAILS

Referral Date
Referral Agency
Contact Person
Primary Reason for Referral
(use reverse if required)

Work Phone
Mobile Phone
Email

Injury Type	Income	Are there currently other agencies? If yes, please provide details
☐ TBI ☐ Stroke ☐ Medical ☐ Neurotoxic ☐ Tumour ☐ Other ☐ Diagnosed ☐ Undiagnosed	☐ ACC ☐ WINZ ☐ Employed ☐ Family PPP&R ☐ Yes ☐ No	☐ Yes ☐ No Are there any staff safety concerns? If yes, please provide details ☐ Yes ☐ No Are there any criminal convictions? If yes, please provide details ☐ Yes ☐ No Is there any mental health/addiction history? If yes, please provide details ☐ Yes ☐ No

How did you hear about us?
Referral Received by

REASON FOR REFERRAL

(What does the client hope to gain from Brain Injury HB?)

PRESENT CIRCUMSTANCES

(Living circumstances, barriers, positive , support networks etc)

RISK ASSESMENT (KESSLER)

Rating: 0 – None 1 – Little 2 – Some 3 – Most 4 – All

So sad nothing could cheer you up?	0	1	2	3	4
Worried or Frightened?	0	1	2	3	4
Restless or Stressed?	0	1	2	3	4
Hopeless?	0	1	2	3	4
That everything was an effort?	0	1	2	3	4
Worthless?	0	1	2	3	4

OFFICE USE ONLY

Service

- Liaison Service
- Whanau Supports
- Support Groups
- Other

Score _______ Priority: Low Med High

Referral date: _____________________

Entered into Exess: _____________________

Allocated Date: _____________________

Allocated to: _____________________

Send completed Referral Form to – support@braininjuryhb.co.nz or call 06 878 6875 ext. 1 to discuss further