Concussion Referral Form

Please email to concussion@axissportsmedicine.co.nz

1. Patient details	
Name:	
National Health Index (NHI) number:	Date of birth:
Phone number:	City/Town:
2. Injury details	
ACC45 number or claim number:	Date of injury:
How many times have you or another provider (if known) seen this client for this concussion?	
Clinical notes attached? ☐ No ☐ Yes	Is this concussion: ☐ the principal injury ☐ an additional injury?
Glasgow Coma Scale score:	Post-Traumatic Amnesia score:
What is your suspected or confirmed injury diagnosis?	
☐ **Suspected** injury diagnosis:	
☐ **Confirmed** injury diagnosis, including Read or ICD10 code:	
Briefly describe how the injury occurred, e.g. the mechanism of injury: ☐ Refer to clinical notes	

Which of the following symptoms were present at the time of consultation? Please tick all that apply.				
☐ Loss of consciousness reported		☐ Mood changes (e.g. depression, anger)		
☐ Loss of balance	☐ Fatigue	☐ Visual disturbances	☐ Difficulty concentrating	
☐ Headaches	☐ Muscular aches	☐ Nausea	☐ Dizziness	☐ Memory problems
List any other symptoms that are relevant to this referral: ☐ Refer to notes				
List any pre-existing factors that may impact recovery: ☐ Refer to notes				

3. Referrer details	
Referrer name:	Provider number:
Practice or department name:	Contact phone number:
4. Referrer signature	
If this referral includes a confirmed diagnosis of concussion, we need a qualified medical professional to sign it, e.g., a 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:	☐ Medical (ED, GP) ☐ Hospital
Signature:	Date:

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SPORTS MEDICINE SPECIALISTS