Queensland Government

Metro North Health

BRAIN INJURY COMMUNITY INTEGRATION SERVICE (BICS)

REFERRAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

ATTACH A DISCHARGE / MEDICAL SUMMARY TO THIS REFERRAL

Client consent: ☐ Yes ☐ No Date of referral:

Reason if no:

Client consent to access QLD Health Medical Records: ☐ Yes ☐ No

PERSONAL

Does the client live alone? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Separated ☐ Widowed ☐ Married/Defacto ☐ Divorced ☐ Unknown

Phone (usual): Phone (other): Email:

Aboriginal and/or Torres Strait Islander:

☐ Aboriginal not Torres Strait Islander ☐ Torres Strait Islander not Aboriginal

☐ Both Aboriginal and Torres Strait Islander ☐ Not Aboriginal or Torres Strait Islander

Country of birth: Religion:

Language: Interpreter required: ☐ Yes ☐ No

Gender: ☐ Man ☐ Woman ☐ Non-binary ☐ Other

Client compensable status:

☐ Work Cover QLD ☐ NIISQ ☐ NDIS ☐ Not eligible ☐ Other ☐ Unknown

What is the client's NDIS/NIISQ status at the time of this referral?

Does the client have an Enduring Power of Attorney? ☐ Yes ☐ No ☐ Unknown

If yes, name: Phone:

QCAT Orders:	Application Submitted	Appointed Guardian	Appointed Administrator
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medicare Number: ID: Expiry: HCC/Pension Number: Expiry:

DVA: Card no: Expiry:

Private Health insurance: Card no: Provider:

GP Name: Phone:

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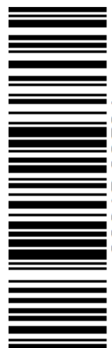
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CONTACT

Significant person: Relationship:

Address: Suburb:

Phone: Email:

Next of Kin (if different): Relationship:

Address: Suburb:

Phone: Email:

ELIGIBILITY INFORMATION

Is the client:

Adult working age range (typically 16 to 70 years)	☐Yes ☐No
Queensland resident and living in the community	☐Yes ☐No
Residing or temporarily living in Metro North catchment	☐Yes ☐No
Medically stable	☐Yes ☐No
Has the Client sustained an adult-onset ABI	☐Yes ☐No
If yes – select injury type	
Traumatic brain injury (penetrating/non-penetrating)	☐
Infections and inflammatory process e.g., meningitis (infective, viral), encephalopathy	☐
Haemorrhage (subarachnoid, subdural, parenchymal)	☐
Hypoxic brain injury with complex ABI rehabilitation specific needs	☐
Haemorrhagic or ischaemic stroke with complex ABI rehabilitation specific needs	☐
Other:	

If selecting no, please contact the service to discuss the case further where referrals do not meet criteria for acceptance.

REASON FOR REFERRAL

Does the client require:

Clinical case management, rehabilitation specific intervention and/or ABI training and consultancy to optimise community reintegration and further establish ongoing/sustainable networks of support in the community.
☐Yes ☐ No

Have specific, achievable community integration or quality of life goals which are impacted by functional, activity or participation limitations, maladaptive behaviour, or social elements.
☐Yes ☐ No

Selecting no to any of the above criteria makes the client ineligible for the BICS service.

Outline goals for BICS intervention:

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DIAGNOSIS/MEDICAL HISTORY

Principal diagnosis:

Acute care hospital: Admitted: Discharged:

Rehabilitation hospital: Admitted: Discharged:

Additional diagnosis/medical history:

Ongoing medical intervention (e.g. chemotherapy/radiation/dialysis):

RISK SCREEN

☐ No risk identified

☐ History of aggression or violence

☐ Expressing intent to harm others; access to available means

☐ History of inappropriate sexual behaviour

☐ Animals

☐ Weapons

☐ History of suicidal ideation. Has plan/intent.

☐ Current or recent drug and/or alcohol abuse

☐ Any information about friends or relatives who may pose a risk

☐ Forensic history that may impact on service provision Location/access issues

☐ Other:

Comments:

PHYSICAL STATUS (Mobility, aids, adaptations):

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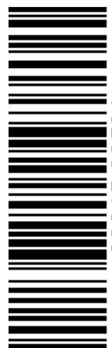

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COGNITIVE STATUS (Formal assessments, strategies, supports):

SPEECH AND COMMUNICATION (Expressive / receptive difficulties, communication partner, ability to communicate in emergency situation):

SELF CARE/CARE NEEDS (Aids / adaptation / formal and informal care supports):

VOCATION/RECREATION (Previous participation / expressed interests' goals):

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SOCIAL/FAMILY ISSUES (Existing supports / risks to sustainability or breakdown / carer strain):

MENTAL HEALTH / PSYCHOSOCIAL / BEHAVIOUR (Risks to self or staff / strategies utilised/ positive behaviour support plan):

REFERRER DETAILS

Name:

Address/Agency/Practice:

Phone: Designation:

Email address:

Please email your completed referral and any support documentation to MN-BICS@health.qld.gov.au

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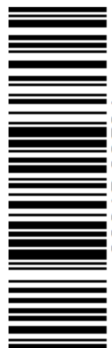

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