



Queensland Government

Metro North Health

BRAIN INJURY COMMUNITY INTEGRATION SERVICE REFERRAL

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Referrals to be sent to mn-bics@health.qld.gov.au

Referral Details

Date of referral:

Referrer's name:

Signature:

Designation:

Address:

Phone:

Email:

Client consent: Yes No → Reason:

Client consent to access QLD Health Medical Record: Yes No Discharge Summary / Medical Summary attached: Yes

Client Details

Does the client live alone? Yes No

Gender: Man Woman Non-binary Other

Marital Status: Single Separated Widowed Married/Defacto Divorced Unknown

Address:

Phone (usual):

Phone (other):

E-mail:

Aboriginal and/or Torres Strait Islanders: Yes No

Interpreter required: No Yes → Language:

Client Compensable Status: Work Cover QLD NIISQ NDIS Not eligible Other Unknown

Enduring Power of Attorney: N/A No Yes → Provide relevant details (e.g. has the EPOA been enacted?)

QCAT Orders:

Application Submitted: Yes No Appointed Guardian: Yes No Appointed Administrator: Yes No

Contact details:

Significant Person:

Next of Kin (if different):

Relationship:

Relationship:

Address:

Address:

Phone:

Phone:

Email:

Email:

GP details:

Name:

Practice

Address

Phone:

Eligibility Information

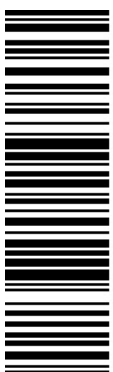
Is the client:

Aged 16 or above Yes No Residing /temporarily within Metro North HHS Yes No

Queensland resident and living in the community Yes No Medically stable Yes No

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DO NOT REPRODUCE BY PHOTOCOPYING

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Eligibility Information cont.

Which of the following injury types does the client have a diagnosis of:

- Traumatic Brain injury (penetrating/non penetrating)
- Brain Infections and inflammatory process e.g. meningitis, encephalopathy
- Brain Haemorrhage (subarachnoid, subdural, parenchymal)
- Hypoxic brain injury
- Haemorrhagic or ischaemic stroke with complex ABI rehabilitation specific needs
- Other:

Client must meet the above inclusion criteria to be ineligible for the BICS

Diagnosis/Medical History

Principle Diagnosis:

Acute Care Hospital:

Discharge date:

Outpatient/Community Rehabilitation Services:

Discharge date:

Additional diagnosis/medical history:

Ongoing medical interventions (e.g. Chemotherapy/Radiation/dialysis)

Risk Screen

(to ensure the safety of BICS staff please complete this Risk Assessment fully and carefully)

- | | |
|--|---|
| <input type="checkbox"/> No risk identified | <input type="checkbox"/> History of suicidal ideation (has plan/intent) |
| <input type="checkbox"/> History of aggression or violence | <input type="checkbox"/> Current or recent drug and/or alcohol abuse |
| <input type="checkbox"/> Expressing intent to harm others; access to available means | <input type="checkbox"/> Any information about friends or relatives who may pose a risk |
| <input type="checkbox"/> History of inappropriate sexual behaviour | <input type="checkbox"/> Forensic history that may impact on service provision |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Location/access issues |
| <input type="checkbox"/> Weapons | <input type="checkbox"/> Other: |

Comments:

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Reason for Referral/Goals for BICS Program

Medical and/or therapy reports should be included with this referral

Please include:

- Physical Status (mobility, aids, adaptations)
- Cognitive Status (Formal assessments, strategies, supports)
- Family supports and social situation
- Behaviour
- Speech and Communication
- Care needs and supports
- Vocation and recreation
- Other agencies involved (NDIS service provider details, NIISQ)

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Office Use Only: Eligibility Screening

Date referral received:

Previous client: Yes No

Eligible: Yes No → Reason

Allocated to:

Date: