



ACQUIRED BRAIN INJURY MOBILITY SERVICES
REFERRAL FORM



CLIENT DETAILS

Name: _____ Date of Birth: _____

Sex: Male Female

Address: _____

Postcode: _____

Phone: _____ Mobile: _____

Email: _____

MEDICAL STATUS

Is the client medically stable? Yes No

Medical History

(please complete attached Medical, Diabetic, Asthma & Epilepsy Action Plans)

Contra-indications for program: _____

Local Doctor's Name: _____

Local Doctor's Address _____

Postcode: _____

Local Doctor's Phone: _____

NATURE OF ACQUIRED BRAIN INJURY

Site of Lesion: _____ Date of Incident: _____

Vision Status: _____

Has the client had a formal vision assessment? Yes No

Please state the name of the Specialist? _____

DEGREE OF MOTOR IMPAIRMENT

	Nil	Mild	Severe	Comments
Balance				
Stamina				
Gait (aids)				

DEGREE OF SENSORY – PERCEPTUAL IMPAIRMENT

	Nil	Mild	Severe	Comments
Vision Loss				
Other Sensory Loss				
Visual Processing Problems				
Inattention/Neglect Vision				
Inattention/Neglect Body				
Spatial Orientation				

DEGREE OF COGNITIVE IMPAIRMENT

	Nil	Mild	Severe	Comments
Language Receptive				
Language Expressive				
Problem Solving				
Planning				
Initiation				
Attention/Concentration				
Memory				
Insight				
Self-monitoring				
Impulsivity				

REHABILITATION STATUS

Is the client an in-patient **OR** an out-patient

Please state approximate discharge date: _____

What therapies (in or out patient) is the client involved in? _____

What days and times is the client involved in therapy? _____

Is the client's rehab program funded by a specific department?

TAC Veterans Affairs Workcover

Please provide Claim/Pension Number: _____

Case Manager's Name: _____

Where is the client mobilising independently on foot?

Rehab Centre Home Local Area Shops Public Transport

What independent mobility goals does the client have? _____

What status is the client's drivers licence? Current Suspended
Cancelled Not Applicable

SOCIAL/FAMILY STATUS

Please list family / significant contacts: _____

Previous Accommodation: _____

Future Accommodation: _____

Is an interpreter needed to communicate with the client? Yes No

If yes, please state which language: _____

REFERRAL CONTACT

Name: _____

Position: _____

Agency: _____

Address: _____

Telephone: BH _____ Mobile _____

PLEASE RETURN COMPLETED FORMS TO:

Shelley Pannier, Team Leader
Acquired Brain Injury Mobility Services
Guide Dogs Victoria
Private Bag 13, Kew, 3101

Telephone: 03 9854 4444 - Facsimile: 03 9854 4466
Website: www.guidedogsvictoria.com.au