Complete this form when a patient with a traumatic brain injury, multi-trauma or spinal cord injury requires an early cover decision so that ACC assign a case manager who can contribute to discharge planning before the client’s discharge from hospital.

When you’ve finished, please **email** the form to the ACC Cover Assessment Centre [earlycover@acc.co.nz](mailto:earlycover@acc.co.nz)

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Client details | | | |
| Name: | | Alternative contact details | |
| Date of birth: | | Name: | |
| Address: | | Telephone: | |
| NHI Number: | | Relationship: | |
| 2. Injury related details | | | | |
| ACC45 number: | ACC45 previously submitted: Y  N | | | |
| Date of injury: | Estimated date of discharge (if known): | | | |
| Hospital: | Intended discharge destination (if known): | | | |
| Ward: |  | | | |
| Is an ACC case manager required prior to discharge? Y  N | | | | |
| Is the client likely to need ACC funded services for more than 60 days following discharge? Y  N | | | | |
| 3. Documentation | | | | |
| Please provide the following information with the early cover application. | | | | |
| ACC45 (mandatory to include and ensure a diagnosis is present on the form) | | | Y | |
| ACC18 (mandatory to include if the diagnosis has changed or not present on the ACC45) | | | Y  Not applicable | |
| Ambulance report | | | Y  Not applicable | |
| Radiology reports (CT scan, MRI scan, angiography) | | | Y  Not available | |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. Other relevant information | | | |
| There is a known previous medical or current medical history that may be relevant to the management or determination of cause of this injury | | | Y  N |
| If yes, provide relevant other information, for example pre-existing pathology or conditions, and evidence-based rationale as to why any pathology is more probable due to an (the) accident rather than any other cause including idiopathic. | | | |
|  | | | |
| 5. Likely support needs on discharge | | | |
| Please indicate the likely support needs on discharge if known | | Tick if relevant | |
| Unknown or unclear at this stage | | Y | |
| Specialist inpatient or residential rehabilitation service (e.g. TBIRR) | | Y | |
| Concussion Service | | Y | |
| Training for Independence Service | | Y | |
| Home and Community Support Services | | Y | |
| Equipment | | Y | |
| Other, please specify: | | | |
| 6. Hospital contact details | | | |
| Person ACC should contact to discuss the client’s situation. | | | |
| Contact person’s name: | Telephone: | | |
| Ward (if different from above): | Email: | | |
| 7. Provider signature | | | |
| Person who completed this form. | | | |
| Name: | | | |
| Signature: | Date: | | |

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC’s privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.