



Date: _____

Referral Form

The North Dakota Brain Injury Network (NDBIN) is intended to provide information about brain injury and assist in accessing services. This is a FREE follow-up service, and can be discontinued at any time.

I would like NDBIN to contact: Individual Personal Representative

Individual Information

Individual's Name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Date of Injury: _____ Cause of Injury: _____

Housing situation: living alone living with family living with other caregiver other _____

Personal Representative Information

Representative's Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Relationship to individual: _____

Services interested in (please check all that apply)

- Community Resources-Provide information regarding access to community based resources and assistance in accessing services.
- Brain Injury Information-Access to brain injury specific information, education and materials for individuals, family, and providers.
- Support Groups-Offer information regarding regional and virtual supports groups.
- Survivor Connections-Structured program providing telephone based connection between individuals with lived experience and those new to brain injury.
- Case Consultation-Individualized technical assistance for professionals to increase success supporting individuals and families experiencing brain injury.
- Other: _____

I give permission for my clinic/provider to forward this form on my behalf to the North Dakota Brain Injury Network. After the provider sends this referral form, a representative from NDBIN will contact me about resources, support and educational opportunities that are available to my family and I.

Signature of individual or authorized representative: _____

Date: _____ Submit completed form via Fax (701) 777-1431 or email info@ndbin.org.

To be completed by forwarding provider

Organization Making Referral: _____

If applicable please provide

Provider's Name: _____ Phone: _____ Email: _____