North Dakota Brain Injury Network

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:_____