ARKANSAS SPINAL CORD COMMISSION
Central Registry Referral Form

ASCC-1
1/15

1501 North University, Suite 470
Little Rock, AR 72207-5233

501-296-1788
1-800-459-1517
501-296-1787 (fax)
ascc@arkansas.gov (email)

CLIENT/PATIENT INFORMATION

Trauma Band Number (if applicable) ____________________

Name ______________________________ **Parent/Guardian** ______________________

Address ______________________________ **Phone No.** ________________

______________________________ **Date of Birth** ________________

City State Zip Code County

SSN ________________ **Sex** ________ **Marital Status** ________ **Dependents** ______

Veteran **Yes** ☐ **No** ☐ **Service Connected** **Yes** ☐ **No** ☐

Worker's Comp **Yes** ☐ **No** ☐

MEDICAL INFORMATION

Disability ______________________________ **Date of Onset** ____________

Cause of Disability ______________________________ **Level of Disability** ____________

Extent of Disability ______________________________

Referred By ________________ **Agency** ____________ **Phone No.** ____________

Attending Physician ______________________________ **Phone No.** ____________

Hospital ______________________________ **Room No.** ____________

MEMORANDUM

TO: ______________________
FROM: ______________________
DATE: ______________________

Contact must be made no later than 10 calendar days from the date of this referral (contact due). A written response [Initial Assessment (ASCC-22), Central Registry Referral Form (ASCC-1), and Surveillance Questionnaire (ASCC-3)] must be submitted to Central Office within 10 calendar days of the initial interview.

cc: Central Office