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| **Name:** **Male/Female/Other****DOB:****Address:****Telephone:****Email:** | **Referrer Name** (if not self-referral):**Relationship/Role:****Address:****Telephone:****Email:** |
| **GP Details** **Name:** **Address:****Telephone:****Email:**  | **Next of Kin/Emergency Contact Details****Name:** **Address:****Telephone:****Email:** |
| **Date of referral:** |

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| **History of Acquired Brain Injury (ABI)** **Date of ABI: Diagnosis :****Cause of ABI:** |

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| **Past Medical History****Epilepsy: Yes/No Seizures Yes/No** If yes, please give details of type & frequency**Cardiac Problems:** **Orthopaedic Problems (muscular or skeletal):****Respiratory Problems:****Known Allergies:****Current medication:****Any current medical reviews or investigations:** |

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| **Current issues and difficulties being faced by the person** |
|  | **Yes** | **No** | **If yes, please give details** |
| **Physical** |
| **Vision** |  |  |  |
| **Hearing** |  |  |  |
| **Taste/smell** |  |  |  |
| **Speech / communication** |  |  |  |
| **Fatigue** |  |  |  |
| **Mobility** |  |  |  |
| **Weakness** |  |  |  |
| **Sleep** |  |  |  |
| **Cognitive** |
| **Memory** |  |  |  |
| **Attention** |  |  |  |
| **Concentration** |  |  |  |
| **Insight** |  |  |  |
| **Behavioural & Emotional** |
| **Control of emotions & behaviour** |  |  |  |
| **Mood/Anxiety** |  |  |  |
| **Motivation** |  |  |  |

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| **Current hobbies / interests:** (a full ‘Interests checklist’ can be completed on initial assessment) |
| **Social Situation** (Family situation, living arrangements – supported, lives alone, etc.): |
| **Please name any other services / agencies involved with the person** (eg Community Brain Injury Team, Community Stroke Team, OT, Physio, Psychology, Speech and Language Therapist, Social Services, etc…) |
| **Current weekly activities (eg Day Centres, support Groups, etc…)**  | **Days attended** |
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| **Any known risks to self or others?** |
| **Any other relevant information?** |
| **Has the referral been discussed with the client and are they in agreement to be referred? Yes/No****Do we have their permission to contact them directly? Yes/No****Do we have consent to share information with other services (i.e. provide and receive information on their behalf)? Yes/No** |
| **What does the person hope to gain from the service?** |

*Please attach any further information or clinical reports that you feel may be relevant.*

**Completed forms should be returned to:**

**Email: referrals@braininjurymatters.org.uk**

**Or**

**Brain Injury Matters (NI), 5c Stirling House, Castlereagh Business Park, 478 Castlereagh Road, Belfast, BT5 6BQ**

***To be completed by Brain Injury Matters***

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| **Date referral received:** | **Name of recipient:**  |
| **Assigned Client code:** | **Appropriate services:** |