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| **Date of referral:** | |
| **Child/ YP Name:**  **Gender: Male/Female/ Prefer not to say**  **DOB:**  **Address:**  **Contact name& relationship to child:**  **Telephone:**  **Email:** | **Referrer Name:**  **Relationship/Role:**  **Address:** (if not self-referral)  **Telephone/Email:**  **Has family consented to referral?** |
| **GP Details**  (Give name, address and telephone number) | |
| **Please name any other agencies involved with the child**  (E.g. OT, Physio, Psychology, SLT, Social Services etc.) | |

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| **History of Acquired Brain Injury (ABI)** | |
| Confirmed diagnosis of ABI: YES NO  Date of ABI:  Age at time of ABI:  Cause of ABI: | |
| **Past Medical History** | |
| **Epilepsy Yes/No**  **Seizures Yes/No** If yes, please give details of type & frequency | **Current Medication** |

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| **Current issues and difficulties being faced by the child/ YP and/or family** | | | |
|  | **Yes** | **No** | **Is this having an impact on the family?** |
| **Physical** | | | |
| Vision |  |  |  |
| Hearing |  |  |  |
| Taste/smell |  |  |  |
| Speech / communication |  |  |  |
| Fatigue |  |  |  |
| Mobility |  |  |  |
| Weakness |  |  |  |
| Sleep |  |  |  |
| **Psychological** | | | |
| Memory |  |  |  |
| Attention |  |  |  |
| Concentration |  |  |  |
| Insight |  |  |  |
| **Behavioural** | | | |
| Control of emotions & behaviour |  |  |  |
| Mood/Anxiety |  |  |  |
| Motivation |  |  |  |

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| **Family** |
| **How many people are there in the family?**  **Who lives at home with child/YP?**  (Name/Relationship/Age) |
| **Education** |
| **Is the child/YP in education?**  **Name of school:**  **Does the child/YP receive any support in education?** |
| **Social Activities** |
| **Is the child/YP involved in any activities?**  (E.g. Sports, Youth Clubs, Playgroup etc.). |

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| **Major Life Events** |
| **Please describe any previous challenges or difficulties experienced by the child/YP and/or family**  (i.e. Prior to, or not in direct relation to the ABI) |

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| **Family Functioning** |
| **Briefly describe how family functioning in day to day life has been affected.** |
| **What does the Child/YP/Family hope to gain from the Family First Service?** |

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

**Completed forms should be returned to:**

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

**Or**

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