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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 NODate 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**