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

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| **What is the client hoping to gain from the service?** |
| **History of Brain Injury**  **Date: Diagnosis:**  **Cause of injury:** |
| **Medical Issues**  **Epilepsy Yes/No Seizures Yes/No** If yes, please give details of type & frequency  **Cardiac Problems: Respiratory Problems:**  **Orthopaedic Problems (muscular or skeletal):**  **Current medication:**  **Known Allergies:**  **Any current medical reviews or investigations:** |

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| **Please comment on any difficulty with the following** | |
| **Vision:** | |
| **Hearing:** | |
| **Taste/Smell:** | |
| **Speech and Communication:** | |
| **Swallowing:** | |
| **Mobility:** | |
| **Memory:** | |
| **Attention and Concentration:** | |
| **Control of Emotions and Behaviour:** | |
| **Mood/Anxiety:** | |
| **Fatigue:** | |
| **Motivation:** | |
| **Insight:** | |
| **Current hobbies/ interests:** | |
| **Social Situation** (Family situation, living arrangements – supported, lives alone etc.): | |
| **Other services currently involved with client?** | |
| **Current weekly activities** | **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** | |

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| ***\*For Brain Injury Matters completion\****  **Service/ services to be offered:**  **Wellbeing Programme 🞎 Younger Adults Wellbeing Programme (aged 18-30’s) 🞎**  **Sports 4 U 🞎 Adult Links Programme 🞎**  **Counselling 🞎** | |
| **Medical Consent required? Yes/No** | **Par-Q required? Yes/No** |
| **Start date offered** |  |

*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**