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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**