Advocacy and Children and Youth Services Referral Form

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:	

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

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:

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 and Emotional			
Control of emotions & behaviour			
Mood/Anxiety			
Motivation			

<u>Education</u> **Is the child/ young person in education?**	**What year at school is the child/ young person in?**
Name & Address of School	**Does the child/ young person have a statement of Special Educational Needs?** *If so, what stage of the Code of Practice?*
Key contact at school:	**Does the child/ young person receive any support in education?**

Current hobbies / interests:
Social Situation (Family situation, living arrangements etc.):
Please describe any previous challenges or difficulties experienced by the child/young person and/or family:*(i.e. Prior to, or not in direct relation to the ABI)*
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…)

Any known risks to self or others?
Any other relevant information?
Has the referral been discussed with the parent/guardian 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 family 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

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