Referral Form – Adult Services

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

<u>History of Acquired Brain Injury (ABI)</u> **Date of ABI:** **Diagnosis:** **Cause of ABI:**
<u>Past Medical History</u> **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:**

Brain Injury Matters

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Brain Injury Matters (NI), Suite 5C Stirling House, Castlereagh Business Park, 478 Castlereagh Road, Belfast, BT5 6BQ
telephone 028 9070 5125 email info@braininjurymatters.org.uk www.braininjurymatters.org.uk
Registered with The Charity Commission for Northern Ireland NIC103691. Northern Ireland Registration No. 35853.

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Current issues and difficulties being faced by the person			
	Yes	**No**	
Physical			
Vision			
Hearing			
Taste/smell			
Speech / communication			
Swallowing			
Mobility			
Weakness			
Fatigue			
Psychological			
Memory			
Attention			
Concentration			
Insight			
Behavioural			
Control of emotions & behaviour			
Mood/Anxiety			
Motivation			

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Current hobbies / interests: (a full 'Interests checklist' can be completed on initial assessment)	
Social Situation (Family situation, living arrangements – supported, lives alone, etc.):	
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…)	
Current weekly activities (eg Day Centres, support Groups, etc…)	**Days attended**
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**	
What does the person 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:

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

Or

Email: referrals@braininjurymatters.org.uk