



Referral Form

Name: Male/Female DOB: Address: Telephone: Email:	Referrer Name (if not self-referral): Relationship/Role: Address: Telephone: Email: Date of referral:
GP Details (Give name, address and telephone number)	Next of Kin/Emergency Contact Details

Religious Affiliation: **(for monitoring purposes only, no person's name will be identified when we are asked to provide this)**

Roman Catholic Protestant No Religion Other Religion

Does the individual have a brain injury/stroke? <i>** This will need to be verified by the referrer if an agency or with the Person's GP in cases where this is unclear**</i>	(Yes)/No
Is the individual over 16 years old?	(Yes)/No

We ask the following questions to enable us to provide the right support at the right time – so anything that is important for us to know to keep the person Healthy and Safe

Reason for Referral:

What is the client hoping to gain from the service?

Brief History of Brain Injury (Date occurred, diagnosis, cause of injury etc.)

Past Medical History	Known Allergies
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Epilepsy Yes/No Do they have Seizures Yes/No If yes, please give details of type & frequency	Current Medication
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Do you or your dependent have any mobility difficulties? Y/N

Do you or your dependent use a wheelchair? Y/N

Do you or your dependent have a visual impairment? Y/N

If you have answered yes to any of the above, please tell us how best to support you

- Do you or your dependent need help going to the toilet? Y/N
- Do you or your dependent have incontinence problems? Y/N
- Do you or your dependent need help having a drink or snack? Y/N
- Do you or your dependent have any difficulties communicating? Y/N

If you have answered 'Yes' to any of the above, please provide some details of the best way to support you or your dependent in the situation.

Managing risks:

Please tick any risk factors that you feel are especially applicable to you or your dependent
(Tick as many as needed)

Traffic		Choking	
Strangers		Fixations	
Loud noises		Children crying	
Specific fears e.g dogs		Physical contact with other people	
Running off		Danger to others	
Danger to self, including any form of self injury		Other (please describe below)	

Please provide relevant details for any boxes ticked, including any advice you can give to assist us in helping you or your dependent

Please provide any further information that would be important for Head Injury Support Staff to be made aware of.

Permissions:

Emergency Treatment

In the event of an emergency, requiring treatment, I consent to emergency treatment being administered:

_____ (service user)

Signed: _____

Date: _____

Service user OR Next of kin (only if the person is able to consent themselves):

Print Name: _____

IMPORTANT - PLEASE NOTE:

Staff supporting you or your dependent will not administer routine medication or carry out any clinical procedures or treatments during activities unless specifically agreed with the Service Manager. If you or your dependent requires any of the above, you should make your own arrangements for this or discuss them with the Service Manager.

Activities consent

I give consent for
_____ (service user)

to take part in activities organised by Head Injury Support. I understand that while attending these activities, s/he will be under the supervision of our staff and volunteers. While these staff will take every reasonable care your dependent, they cannot be held responsible for any loss, damage or injury incurred.

Signed: _____ Date: _____

Print Name: _____

Photography and Filming Consent.

In keeping with good practice in relation to safeguarding vulnerable adults, I wish to seek your permission for the use of photographs taken of your dependent during activities.

Photographs may be presented or published in:

- Head Injury Support presentations to other agencies.
- Internal notice board displays
- Head Injury Support publications, for example, monthly newsletter, website, Facebook, Twitter or leaflets
- Local or national newspapers (notice will always be given)
- Television programmes (notice will always be given).

Should you wish to withhold your permission for any reason, I will endeavour to ensure that whoever is in charge of the group at the time will exclude your child/young person/adult from the photograph in question. Staff and volunteers will, of course, be aware of Head Injury Support Service policy in relation to such requests and will act in accordance with this. The response you will give will apply during subsequent years unless the Service is otherwise informed.

I consent to photographs being taken and used as described above.

Signed: _____ Date: _____

Print Name: _____

Completed forms should be returned to:

Head Injury Support, 4 Kildare St, Newry, Co Down, BT34 1DQ

Scanned and emailed to (being aware of sharing private data practice - GDPR):

info@headinjurysupport.org.uk

Or Contact for any questions or further information: 028 3083 3728