**REFERRAL FORM**

Headway Cambridge and Peterborough provides services to adults with acquired brain injury and other neurological conditions, across Cambridge and Peterborough, as well as support to their carers, family and friends.

We accept referrals from health care professionals, support/advice agencies, social workers, family members, friends, carers or self-referrals.

The following information will help us decide the most appropriate service to meet the needs of the individual. All information will be treated as confidential and in accordance with our Confidentiality and Disclosure of Information policy.

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| --- |
| Date of referral:  |

|  |  |
| --- | --- |
| Name of person being referred: | Is this person: [ ]  person with brain injury [ ]  family member/carer/friend |
| Address: | Date of birth: |
| Contact no: |
| Email: |
| Ethnicity: |

|  |
| --- |
| Next of kin:  |
| Address:  | Contact no: Email: Permission to contact Next of Kin: Yes [ ]  No [ ]  |

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| --- |
| **Nature of brain injury**: Date of injury: [ ]  Hypoxia [ ]  Road Traffic Collision[ ]  Vascular Event e.g, Stroke, [ ]  Assault [ ]  Fall[ ]  Other (please specify):  |

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| **Key information**If relevant please include any previous assessments, communication difficulties, current addictions, current health needs (including mental health). Please continue on separate sheet if necessary |
| **Details of brain injury:** Please give as much information as possible about the effects of the brain injury in order to help us provide an appropriate service.  |
| **Relevant medical history:** |
| **Social Situation:** |
| **How do you think can Headway support this individual?** |

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| **Are there any known risks?**e.g Medical risks FallsDrugs and alcoholLone worker risks |

Please indicate the type of support requested:

[ ]  Social and emotional support

[ ]  Understanding brain injury

[ ]  Respite for carer

[ ]  Independent living skills (cooking, shopping, household tasks)

[ ]  Social activities

[ ]  Physical activities

[ ]  Cognitive activities

[ ]  Information on Headway services

[ ]  Information on other local services/agencies

[ ]  Signposting to legal services

[ ]  Self-Management Strategies

[ ]  Other (please state)

Other/ Additional Information:

Would you envisage support to be:

[ ]  Hub based (Please indicate for Cambridge [ ]  or Peterborough [ ] )

[ ]  Home/ Community based

Please note; there is a charge for attending some of Headway Cambridge and Peterborough’s Services. How would this be met?

[ ]  Statutory Services (need to meet criteria for funding)

[ ]  Self directed support

[ ]  Self funding (compensation claim/own funds)

[ ]  Other (give details)

Does the person have a Social Worker? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| **Other agencies involved:**[ ]  Social Services[ ]  Housing Support[ ]  Physiotherapy[ ]  Occupational Therapy[ ]  Neuro Psychology[ ]  Other (please specify) | Contact details: |

May we contact any of the above for further information? [ ]  Yes [ ]  No

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| --- |
| Person making referral:Name: Relation to person being referred: Address: Job Title: Contact No: Email:  |

Have you had contact with Addenbrooke’s Hospital’s Headway Advisor? [ ]  Yes [ ]  No

**Is the person aware of referral** [ ]  Yes [ ]  No

**Return to: Headway Cambridge and Peterborough**

 **4 Woolgate Court, St Benedict’s Street, Norwich, NR2 4AP**

 **Email:** **contact@headway-nw.org.uk**

 **Telephone: 01223 576550**