Headway North Staffordshire
(Head Injuries Association) Ltd
Headway House, Elder Road, Cobridge, Stoke-on-Trent, ST6 2JE
Tel: 01782 280952 Email:headwayns@hotmail.com

Headway House Referral Form

Making a referral:

This form can be completed by people seeking rehabilitation and respite support from Headway North Staffordshire; it can also be completed by Health Professionals.

What happens next?

Completed referrals can be emailed to philippa.headwayns@hotmail.co.uk

You can also deliver, or post referrals to Headway House, Elder Road, Cobridge, Stoke on Trent ST6 2JE

Once a completed referral form is received a member of the team will contact you to arrange a face to face meeting.

During the meeting you will be offered a date and time to come into Headway to look around the service and see the facilities on offer, and also have the opportunity to meet the members and staff.

We will also discuss our Outreach / PA service dependant on your needs.

Funding:

There is a daily rate charged to access all of our rehabilitation and respite facilities, depending on your needs, this will be discussed during your visit to Headway House.

We can offer support to look into funding options from Social Care

The Outreach /PA service is a separate hourly rate of for social activities and varies for personal care/medication needs.

Complementary Therapy services (relaxation/massage etc.)are also available for a small fee

Headway North Staffordshire conforms to an Equal Opportunities Policy available on request.

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Personal Details

Name:	Date of Referral :
D.O.B/Age :	Gender:
NI Number:	NHS Number:
Address of person being referred:	What area do you live in:
What's your first language:	Do you require a translator :

Source of Referral: Contact Details Inc. Address:	Next of Kin details: Name and relationship
Email: Mobile number: Home Number:	Next of kin's address and contact details:

Primary Medical Information:

Medical History: Acquired Brain injury/ Traumatic Brain injury and Stroke related Brain Injuries:

Medication Inc. (possible side effects, allergic reaction)

GP / Consultants Details:

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Secondary Medical Information (Diabetic, Asthmatic, food allergies, dietary requirements)

Referral needs

OT service: potential for rehabilitation areas Please tick if required: Home assessment: Assessments for carers: Assessment for Headway House:
Intervention sessions that are offered. Tick if required: Social skills: Social integration/ inclusion: Budgeting skills: Assertiveness: Anger management: Sleep management: Self-esteem: Mindfulness: One to one wellbeing time: Memory work: Assessment of motor and process skills: Daily living activities: Transport training:
Gym Therapy : Please note any gym/therapy needs will be decided after induction /assessment Please indicate therapy requirements Gym Based Therapy Based Gym & Therapy **Current Mobility :** Independent : Use of walking aid/wheelchair (please specify) Current Exercise Level: i.e. walking /swimming etc. **Potential restrictions/ medical condition that may affect exercise**

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Previous Physiotherapy Input :

Type of Therapy Dates When Seen Details of Physiotherapist

Clinical Complementary Therapies Wanted

Reflexology: Mindfulness:

Relaxation: Massage:

Aromatherapy : Meditation:

Wellbeing workshops :

(please note that before any treatment can take place the section below needs to be completed)

Do you have any of the following conditions? Please circle.....

Fungal conditions Skin Disorders Infectious diseases Joint problems

Muscular problems Osteoarthritis Rheumatoid Arthritis Falls Fractures

Plates Pain Cancer Lung Conditions Asthma

Heart conditions Thrombosis / Varicose veins Unstable blood pressure

Pregnancy Headaches Dizziness Bowel / Bladder conditions Peg Feed

OTHER

Allergies Yes / No Details _____

_____

If you have any of the above please provide details

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Please provide the following information.

Do you have any of the following conditions?

Epilepsy Yes / No Controlled Yes / No

Seizures Yes / No pre-warning Yes / No

Type petit mal grand mal convulsion

Muscle spasm drop vacant other .....

Brain Tumour Yes / No Malignant Yes / No Removed? Yes/ No

Any History of ? Yes / No _____

Stroke / History Yes / No Left / Right

Cause Trauma Accident aneurism embolism Cardio vascular

Shunt ? Yes / No Left / Right Function? .....

Anticoagulant Warfarin (INR stable Yes / No) aspirin other .....

Do you use any of the following ?

Wheelchair Yes / No Transfer Yes /No

Stick Yes / No Left /Right

Frame Yes / No

Other Yes / No

Do you have any of the following?

Diabetes Yes / No Controlled Yes / No Diet / Meds

Communication difficulties Speech Memory Sight Hearing

Overall wellbeing issues Sleep Anxiety Depression Appetite

Sensory impairment Touch Taste Smell Hypersensitivity

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Any other relevant information
Outreach /PA service Social Activities: Personal care / Medication:
Legal Advice Yes /no

Your accommodation and household

What type of accommodation are you currently living in Tick as appropriate Family / friends : Shared housing : Hostel: Owner occupier: Residential respite: Supported / sheltered scheme: Housing association / council: Private rent: Other : Do you need help from us to signpost to services : i.e. OT/ housing officers:

Please include other people that currently live with you including children		
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

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Pets you may have :

Do You Smoke in the house?

Is there antisocial behaviour in the area?

Is the property safe to enter : i.e. hoarding

Is there adequate parking available at the property?

Other Agency Involvement.

Support from other agencies:			
Name	**Title**	**Agency Address**	**Contact Details**

Please tick below any areas below that you need

Housing i.e. suitable accommodation/ adaptations	Physical health i.e. register with a doctor
Tenancy issues i.e. landlord disputes	Mental health and wellbeing/ signpost to services
Managing money i.e. setting up direct debits/ budgeting	Identification: support to access birth certificate
Debt : i.e. referral to services	Living skills i.e. cooking , food shopping
Benefits i.e. PIP / ESA	Education : to look for free learning
History of offending/ signposting to services	Local community: support to access
Drug misuse /signpost to services	
Alcohol misuse /signpost to services	

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Income details : i.e. benefits received

Have you got permission to remain in the UK?

Yes no	Exceptional permission to remain
Discretionary permission :	Humanitarian protection
Refugee status :	Indefinite permission to remain

Do you have any cultural, religious, or sexual orientation needs / if yes How can we meet these needs?

How is your place likely to be funded?

Self **Direct payments** **Managed account** **Health**

The consent below is to allow us to record information about your referral form

Signed by Applicant:	Date:
Signed by Referrer:	Date:

Form available in larger print if needed contact Headway North Staffs on 01782 280952

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Risk Assessment

Name:	Referrer Name:	Date Completed :

Risk severity & probability chart

Severity			Probability		
1	Negligible	Will not result in serious injury possibility of minor first aid	1	Extremely remote	Unlikely to occur
2	Marginal	Could cause illness injury or damage to equipment or person but result not serious	2	Remote	May occur over time
3	Critical	Can result in serious illness severe injury, to property , equipment person	3	Reasonably probable	Will probably occur
4	Catastrophic	Imminent danger wider scale illness, capability of causing death	4	Probable	Likely to occur immediately

Low Risk 1-4	Medium Risk 6-9	High Risk 12- 16

A	Physical Health	Yes	No	Severity	Probability	Risk
1	Current physical health is a concern					
2	Has acute physical health issues (mobility)					
3	Has long term physical health issues (diabetes/asthma)					
4	No access to medical care for 6 months (GP hospital)					
Additional information						

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B	Anger Management	Yes	No	Severity	Probability	Risk
1	Occasional loss of temper					
2	Has repeated incident of verbal and /or physical aggression					
3	Self or others are concerned by levels of aggression					
4	Concerns of aggressive behaviour to self or others is increased due to triggers					
Additional information						

Low Risk 1-4	Medium Risk 6-9	High Risk 12- 16

C	Mental Health	Yes	No	Severity	Probability	Risk
1	Mental health diagnosis					
2	Are services involved					
3	Do you feel your mental health is of concern					
4	Do you need signposting to services					
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Low Risk 1-4	Medium Risk 6-9	High Risk 12- 16

D	Self -Harm	Yes	No	Severity	Probability	Risk
1	Current incidents/evidence threats of self harm (please state)					
2	Previous incidents of self-harm(time frame)					
3	Previous suicide attempts / suicide thoughts(time frame)					
4	Current suicide thoughts /attempts (time frame)					
Additional information						

Low Risk 1-4	Medium Risk 6-9	High Risk 12- 16

E	Harm to others(Racial,Sexual,Physical,Intimidation)	Yes	No	Severity	Probability	Risk
1	Express intent to harm others					
2	History of harm to others/convictions					
3	Use of a weapon against another					
4	Previous /current incidents of Domestic Violence against another					
Additional information						

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F	Alcohol or Drug use	Yes	No	Severity	Probability	Risk
1	Do you currently drink alcohol or use illegal Drugs					
2	Do you have support from another service(workers name)					
3	Do others have concerns regarding your alcohol or drug intake					
4	Do you feel there are any triggers (stress, depression)					
Additional information						

Low Risk 1-4	Medium Risk 6-9	High Risk 12- 16

G	Harm to children	Yes	No	Severity	Probability	Risk
1	Currently any child protection investigations going on					
2	Currently under any CIN /CAF					
3	Any convictions for harm/abuse to a child					
4	Do you have any concerns regarding your children(signposting)					
Additional information						