**Headway North Staffordshire Referral Form**

**Making a referral**

Headway North Staffordshire’s services are available to **adults with an acquired brain injury (ABI), either because of trauma, stroke or disease.**

Please complete the initial assessment form and email the completed form to: [referrals@headwaynorthstaffs.org](mailto:referrals@headwaynorthstaffs.org). 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 at Headway House. During the meeting we will find out more about your support needs and discuss how we can help you.

**Cost**

There is a daily rate charged to access all our services, depending on your needs. This will be discussed during your visit to Headway House. You might be eligible for social care funding to help cover the costs.

**Guidance on completing the referral form -**

**Only complete the part of the form that are relevant your referral.**

Please complete the following sections for **ALL** referrals:

HOW WE CAN HELP

PERSONAL DETAILS

FINANCIAL DETAILS

PRIMARY MEDICAL INFORMATION

If you are requesting Rehab or Gym Services, please complete sections:

**Sections as listed for ALL referrals, plus:**

ABOUT YOU AND YOUR HEALTH

GYM SERVICES

Physical Activity Readiness Questionnaire (PARQ)

If you are requesting Outreach Services **ONLY**, please complete sections:

**Sections as listed for ALL referrals, plus:**

ABOUT YOU AND YOUR HEALTH

ALL SECTIONS WITHIN OUTREACH SERVICES

**For multiple service selections please follow the guidance for each service as above.**

**How we can help you**

**Rehab Services**

Headway North Staffordshire provides a range of day services that aid rehabilitation, develop practical skills, and give opportunities for people to socialize. Delivered from Headway House, these activities include arts and craft workshops, IT sessions, cookery classes, woodwork/carpentry training, physical activity sessions and quizzes.

**Gym and physiotherapy**

Headway North Staffordshire’s experienced staff work with service users to agree an individualised exercise programme, including balance retraining, strengthening exercise and cardiovascular training.

**Outreach Services**

Headway North Staffordshire’s experienced outreach team provide one-to-one support to people with Acquired Brain Injuries (ABI), helping them maximise their independence both at home and in the community. Outreach workers can help people to access social activities and attend appointments. The outreach service can also provide support with aspects of day-to-day living e.g. preparing a shopping list, making meals and snacks.

**Please indicate what services you are interested in.**

|  |  |  |  |
| --- | --- | --- | --- |
| Outreach / personal assistance |  | Gym and physiotherapy |  |
| Rehab services |  |  |  |

**Personal Details**

|  |  |
| --- | --- |
| Name: | Date of referral: |
| Date of birth: | Gender: |
| Ethnicity: | NHS Number: |
| Address of person being referred: | Telephone Number  Home:  Mobile:  Email: |
| What’s your first language? | Do you require a translator? |

|  |  |
| --- | --- |
| Source of referral:  Contact Details  Address:  Telephone number:  Email: | Next of kin details:  Name  Address  Telephone number:  Email: |

|  |
| --- |
| **Please give details of any hobbies and interests you may have.** |
|  |

|  |
| --- |
| **Do you have any cultural, religious, or sexual orientation needs? If yes, how can we meet these needs?** |

**FINANCIAL**

|  |  |  |  |
| --- | --- | --- | --- |
| **How is your place likely to be funded?** | | | |
| Self-funded |  | NHS funded |  |
| Local Authority funded |  |  |  |
| Is your funding already in place | | Yes | No |

|  |  |
| --- | --- |
| **Do you need assistance with funding?** | |
| Yes | No |

|  |
| --- |
| **Do you have an allocated social worker? Please provide details** |
| Name  Local Authority  Telephone number  Email address |

**Primary Medical Information**

|  |  |
| --- | --- |
| GP surgery name  Address  Post code | Telephone number |

|  |  |  |  |
| --- | --- | --- | --- |
| **What was the cause of your brain injury?** | | | |
| Road traffic accident |  | Assault |  |
| Accident |  | Stroke |  |
| Tumour |  | Brain haemorrhage |  |
| Other | Please specify | | |

|  |  |
| --- | --- |
| **When did the brain injury occur?** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Resuscitation status**  Do you have a Do Not Attempt Resuscitation order in place? | | | |
| Yes |  | No |  |

**About you and your health**

|  |  |  |
| --- | --- | --- |
| Do you live alone? | Yes | No |
| If the answer is no, how many people live with you? |  | |

**Do you have any of the following?**

|  |  |  |
| --- | --- | --- |
| **Epilepsy** | Yes / No | Is it controlled? Yes No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Seizures**  **Type** | Yes / No | Pre-warning? Yes No | | |
| Petit mal | Grand mal | Convulsion | |
| Muscle spasm | Drop | Vacant | Other |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Anticoagulant** | Warfarin (INR stable)  Yes / No | | | | | Aspirin  Yes / No | | | | | |
| **Shunt** | | Yes / No | | Left side Right side | | | | | Function | | |
|  | |  | |  | | | | |  | | |
| **Dysphagia** | | | Do you have problems swallowing certain foods or liquids?  Yes No | | | | | Please provide details | | | |
| **Diabetes** | | | Yes No | | Is it  controlled? | | Yes No | If so, how? | | Diet Medication | |
| **Communication difficulties** | | | Speech | | Memory | | | Sight | | | Hearing |

|  |
| --- |
| **Medication (including possible side effects, allergic reaction)** |

**Additional medical information (e.g., asthma, food allergies, dietary requirements)**

|  |
| --- |
|  |

**Mobility and Physical Activity**

|  |  |  |
| --- | --- | --- |
| **Are you currently having or have had physiotherapy in the past, please provide details** | | |
| Type of therapy | Dates | Details of physiotherapist |

**If there is any further information that you would like to share with us, please provide details below. The more information we have about you will help us help you.**

|  |
| --- |
|  |

**Gym Services**

For all service users with an acquired brain injury occurring 0-6 months ago, or discharge from hospital within 6 months please provide information in the table below. This information has to be provided by the referee in line with neuro-surgical advice in order for any physical therapy to take place.

|  |  |
| --- | --- |
| **Type of exercise** | **Precaution** |
| Low intensity weighted / resistance exercise e.g., hand weights | \_\_\_\_\_\_\_\_\_ weeks |
| High intensity weight / resistance exercises e.g., weighted cable machine | \_\_\_\_\_\_\_\_\_ weeks |
| Please specify any precautions to completing weighted exercise |  |
| Low intensity cardio-vascular exercise e.g., treadmill training, walking speed | \_\_\_\_\_\_\_\_\_ weeks |
| High intensity cardio-vascular exercise e.g., incline treadmill training or treadmill training jogging pace. | \_\_\_\_\_\_\_\_\_ weeks |
| Please specify any precautions to completing cardio-vascular exercise |  |

|  |  |  |
| --- | --- | --- |
| **Current mobility** | | |
| Able to move unaided | Yes | No |
| Use of a walking aid or wheelchair needed. | Please specify | |

**Physical Activity Readiness Questionnaire (PARQ)**

If you are between 18 and 69, the PAR-Q will tell you if you should check with your doctor before you significantly change your physical activity patters. If you are over 69 years of age and are not used to being very active, check with your doctor. Please read carefully and answer each one honestly.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? |  |  |
| Do you feel pain in your chest when you do physical activity? |  |  |
| In the past month, have you had chest pain when you were not doing physical activity? |  |  |
| Do you lose your balance because of dizziness, or do you ever lose consciousness? |  |  |
| Do you have a bone or joint problem that could be made worse by a change in your physical activity? |  |  |
| Is your doctor currently prescribing drugs (e.g. water pills) for blood pressure or heart condition? |  |  |
| Do you know of any other reason why you should not do physical activity? |  |  |
| If yes, please comment | | |

**‘Yes’ to one or more questions**

You should consult with your doctor to clarify it is safe for you to become physically active at this current time and in your state of health.

**No to all questions**

It is reasonably safe for you to participate in physical activity, gradually building up from your ability level.

**I have read, understood and accurately completed this questionnaire. I confirm that I am voluntarily engaging in an acceptable level of exercise, and my participation involves risk of injury.**

|  |  |
| --- | --- |
| Signature |  |
| Print name |  |
| Date |  |

**Having answered ‘yes’ to one of the above, I have sought medical advice, and my doctor has agreed that I may exercise.**

|  |  |
| --- | --- |
| Signature |  |
| Print name |  |
| Date |  |

**Outreach Service**

|  |  |
| --- | --- |
| **How many hours would you need in total?** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **What days would you need the service? How many hours for each?** | | | | | | |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
|  |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please tell us about other people who currently live with you, including children.** | | | | |
|  |  | | |  |
| Name: | | Age: | Relationship: | |
| Name: | | Age: | Relationship: | |
| Name: | | Age: | Relationship: | |
| Name: | | Age: | Relationship: | |
| Name: | | Age: | Relationship: | |
| Name | | Age: | Relationship: | |

|  |
| --- |
| **If you have pets, please specify.** |

|  |
| --- |
| **Do you smoke in the house?** |

|  |
| --- |
| **Is the property safe to enter: i.e., hoarding?** |

|  |
| --- |
| **Is there adequate parking available at the property?** |

**Other Agency Involvement**

|  |  |  |  |
| --- | --- | --- | --- |
| **Support from other agencies:** | | | |
| **Agency** | **Contact person** | **Address** | **Contact details** |
|  |  |  |  |
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|  |  |  |  |
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**Please tick below any areas that you need help with**

|  |  |  |  |
| --- | --- | --- | --- |
| Managing money e.g., setting up direct debits/ budgeting |  | Mental health and wellbeing/ signpost to services |  |
| Debt e.g., referral to services |  | Living skills e.g., cooking, food shopping |  |
| Benefits e.g., PIP / Universal Credit |  | Local community: support to access services |  |
| Signposting to legal advice |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you got permission to remain in the UK?** | | | |
| Yes | No | | |
| Discretionary leave to remain (DLR) |  | Leave outside the rules (LOTR) |  |
| Humanitarian protection |  | Refugee status |  |
| Indefinite leave to remain (ILR) |  |  | |