

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



Headway North Staffordshire Referral Form

Making a referral

Headway North Staffordshire services are available to **adults with an acquired brain injury (ABI), traumatic brain injury (TBI) or stroke related head injury**. 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:

admin@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.

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 have the opportunity to meet the members and staff.

We will also discuss our outreach / personal assistant service dependant on your needs.

Funding:

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

We can offer support to explore funding options from social care.

The outreach / personal assistant service is a separate hourly rate for social activities and varies for personal care / medication needs.

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

PLEASE MAKE SURE YOU COMPLETE THE RISK ASSESSMENT AT THE END OF THE DOCUMENT BEFORE RETURNING THE FORM.

Personal Details

Name:	Date of referral
Date of birth:	Gender:
NI Number:	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: Email: Mobile number: Home Number:	Next of kin details: Name and relationship Next of kin's address and contact details:
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Primary Medical Information

GP surgery name	
Surgery address	

Resuscitation status

What was the cause of your brain injury?			
Road traffic accident	<input type="checkbox"/>	Assault	<input type="checkbox"/>
Accident	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Tumour	<input type="checkbox"/>	Brain haemorrhage	<input type="checkbox"/>
Other	<input type="checkbox"/> Please specify		

When did the brain injury occur?	
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Consultant's details, if applicable

Do you have any of the following?

Epilepsy	Yes / No	Is it controlled?	Yes	No
	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Seizures	Yes / No <input type="checkbox"/> <input type="checkbox"/>	Pre-warning? Yes No <input type="checkbox"/> <input type="checkbox"/>		
	Type	Petit mal <input type="checkbox"/>	Grand mal <input type="checkbox"/>	Convulsion <input type="checkbox"/>
	Muscle spasm <input type="checkbox"/>	Drop <input type="checkbox"/>	Vacant <input type="checkbox"/>	Other <input type="checkbox"/>

Shunt	Yes / No <input type="checkbox"/> <input type="checkbox"/>	Left side Right side <input type="checkbox"/> <input type="checkbox"/>	Function
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Anticoagulant	Warfarin (INR stable) Yes / No <input type="checkbox"/> <input type="checkbox"/>	Aspirin Yes / No <input type="checkbox"/> <input type="checkbox"/>
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Do you have any of the following?				
Dysphagia	Do you have problems swallowing certain foods or liquids? Yes No <input type="checkbox"/> <input type="checkbox"/>		Please provide details	
Diabetes	Yes No <input type="checkbox"/> <input type="checkbox"/>	Is it controlled? Yes No <input type="checkbox"/> <input type="checkbox"/>	If so, how? <input type="checkbox"/>	Diet Medication <input type="checkbox"/> <input type="checkbox"/>
Communication difficulties	Speech <input type="checkbox"/>	Memory <input type="checkbox"/>	Sight <input type="checkbox"/>	Hearing <input type="checkbox"/>
Wellbeing problems	Sleep <input type="checkbox"/>	Anxiety <input type="checkbox"/>	Depression <input type="checkbox"/>	Loss of appetite <input type="checkbox"/>
Sensory impairment	Touch <input type="checkbox"/>	Taste <input type="checkbox"/>	Smell <input type="checkbox"/>	Hypersensitivity <input type="checkbox"/>

Medication (including possible side effects, allergic reaction)

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

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Current mobility

Current mobility	
Able to move unaided	<input type="checkbox"/>
Use of a walking aid or wheelchair needed.	<input type="checkbox"/> Please specify
Please specify any restrictions / medical condition that may affect exercise	

If you have had physiotherapy in the past, please provide details		
Type of therapy	Dates	Details of physiotherapist

How we can help you

Day 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 and one-to-one wellbeing sessions.

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.

Counselling

Service users and their families can access six free one-hour counselling sessions.

Outreach

Headway North Staffordshire's experienced outreach team provide one-to-one support to people with ABI/TBI and stroke related head injuries, 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 training in aspects of day-to-day living.

Speech and Language Therapy

A Health and Care Professions Council registered Speech and Language Therapist can provide an initial assessment of language (aphasia/apraxia) and speech disorders

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(dysarthria), and develop personalised therapy programmes to help people achieve their goals.

Please indicate what services you are interested in.

Outreach / personal assistance	<input type="checkbox"/>	Gym and physiotherapy	<input type="checkbox"/>
Day services	<input type="checkbox"/>	Counselling	<input type="checkbox"/>
Speech and Language Therapy	<input type="checkbox"/>		

When would you like the service to start?	
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What days do you need the service delivered?

Please note that day services, counselling, the gym and physiotherapy are only available Monday to Friday.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your accommodation and household

What type of accommodation are you currently living in?			
Owner occupier	<input type="checkbox"/>	Renting – housing association	<input type="checkbox"/>
Renting – private	<input type="checkbox"/>	Renting – council	<input type="checkbox"/>
Family or friends	<input type="checkbox"/>	Supported/sheltered housing	<input type="checkbox"/>
Residential respite	<input type="checkbox"/>	Hostel	<input type="checkbox"/>
Shared housing	<input type="checkbox"/>		

Do you need help accessing relevant services, e.g., housing officers?	
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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

Please tick below any areas that you need help with

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

Income details e.g., benefits received

Have you got permission to remain in the UK?			
Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>		
Discretionary permission	<input type="checkbox"/>	Exceptional permission to remain	<input type="checkbox"/>
Humanitarian protection	<input type="checkbox"/>	Refugee status	<input type="checkbox"/>
Indefinite permission to remain	<input type="checkbox"/>		

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-funded	<input type="checkbox"/>	Managed account	<input type="checkbox"/>
Direct payments	<input type="checkbox"/>	Continuing health care	<input type="checkbox"/>

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 28095

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
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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						

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

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

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