**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:

[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.

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: |

**Primary Medical Information**

|  |  |
| --- | --- |
| GP surgery name |  |
| Surgery address |  |

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

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

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| --- | --- |
| **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 |

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

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| --- | --- | --- | --- | --- |
| **Shunt** | Yes / No | Left side Right side | | Function |
|  |  |  | |  |
| **Anticoagulant** | Warfarin (INR stable)  Yes / No | | Aspirin  Yes / No | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Do you have any of the following?** | | | | | | |
| **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 |
| **Wellbeing problems** | Sleep | Anxiety | | Depression | | Loss of appetite |
| **Sensory impairment** | Touch | Taste | | Smell | | Hypersensitivity |

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

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

|  |
| --- |
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**Mobility and Physical Activity**

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

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 |  |

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| **Current mobility** | |
| Able to move unaided |  |
| Use of a walking aid or wheelchair needed. | Please specify |

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

Please indicate what services you are interested in.

|  |  |  |  |
| --- | --- | --- | --- |
| Outreach / personal assistance |  | Gym and physiotherapy |  |
| Day services |  | Counselling |  |
| Speech and Language Therapy |  |  |  |

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| **When would you like the service to start?** |  |

**What days do you need the service delivered?**

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

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| --- | --- | --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|  |  |  |  |  |  |  |

**Your accommodation and household**

|  |  |  |  |
| --- | --- | --- | --- |
| **What type of accommodation are you currently living in?** | | | |
| Owner occupier |  | Renting – housing association |  |
| Renting – private |  | Renting – council |  |
| Family or friends |  | Supported/sheltered housing |  |
| Residential respite |  | Hostel |  |
| Shared housing |  |  |  |

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| 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: | |
|  | |  |  | |

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

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

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

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

**Other Agency Involvement**

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

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

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| Income details e.g., benefits received |

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| **Have you got permission to remain in the UK?** | | | |
| Yes No |  | | |
| Discretionary permission |  | Exceptional permission to remain |  |
| Humanitarian protection |  | Refugee status |  |
| Indefinite permission to remain |  |  | |

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

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| **How is your place likely to be funded?** | | | |
| Self-funded |  | Managed account |  |
| Direct payments |  | Continuing health care |  |

**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 |

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| --- | --- | --- |
| 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 | | | | | | |

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| 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 | | | | | | |

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| 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 | | | | | | |

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| 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 | | | | | | |

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| 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 | | | | | | |

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| 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 | | | | | | |

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| 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 | | | | | | |