HEADWAY ESSEX CLIENT REFERRAL FORM

Please fill in this form as completely as you can, as this will help us to deal with your enquiry more effectively. If you need help filling in the form, please contact our helpline on 01206 768797.

1. ARE YOU COMPLETING THIS FORM FOR SOMEONE ELSE?
☐ **Yes** *(please continue to section 2)* ☐ **No** I am applying for Headway Services myself *(please complete section 3 onwards)*

2. YOUR RELATIONSHIP TO THE PERSON BEING REFERRED	
Your Name	**In what capacity do you know the person with the brain injury?** ☐ Spouse or Partner ☐ Professional ☐ Family member ☐ Other *(please specify)* ☐ Carer
Name of your agency *(if professional)* **Address:**	**Telephone No:** **Email:**
Is the person aware of this referral ☐ **Yes** ☐ **No** **IMPORTANT -** in order that we can provide support please ensure the person being referred has completed and signed section 9, the declaration and consent form. ***(Please fill in the rest of this form.)***	

3. DETAILS OF PERSON BEING REFERRED		
Title: Mr / Mrs/ Ms, / Miss **First Name** *(known as):*		**Surname:**
Date of birth:	**Gender:**	**Marital Status:**
Current address and postcode: **Telephone No:** **Email:**		
Language and Cultural background (optional) *Your answers help us to develop better services. We use them only to ensure our services reflect the backgrounds of the people we support.*		
Country of origin:	**Can you speak English?** ☐ Yes ☐ No	
Ethnic or cultural background: ☐ Asian ☐ Black - British	☐ Mixed – White/Black ☐ Mixed – White/Asian ☐ White – British	

☐ Black – African ☐ Chinese	☐ White – Irish ☐ Other *(please state)*
Religion:	☐ Rather not say

4. CARERS DETAILS (If Applicable)

Title: Mr / Mrs/ Ms, / Miss **First Name:**	**Surname:**	**Relationship:** ☐ Spouse or Partner ☐ Family member ☐ Professional Carer
Telephone No:	**Email:**	

5. Details of the Acquired Brain Injury (ABI)
(Please provide as much detail as possible, to enable us to gain a better understanding of the overall situation)

Date of injury:	**Do you have medical confirmation of Acquired brain injury?** ☐ Yes - Please provide a copy for our records ☐ No

Cause of Injury:

☐ Road Traffic Collision	☐ Stroke	☐ Tumour removal
☐ Fall	☐ Hemorrhage (bleed)	☐ Alcohol-related brain injury
☐ Sport / Leisure Accident	☐ Meningitis or Encephalitis	☐ Other *(please specify)*
☐ Assault / Violence	☐ Anoxia/Hypoxia (lack of oxygen)	

Injuries sustained at time of incident:

Provide details of current health conditions:

- **Medical health**
- **Emotional/Mental health**
- **Physical health**

What are the current issues/concerns?

How can Headway Essex help?

Please supply any other information that you feel is relevant to enable us to support you.

Would you be able to travel to one of our offices in Benfleet, Colchester or Epping to meet with a worker if required?
☐ Yes ☐ No

6. SUPPORT/SERVICES CURRENTLY IN PLACE

What benefits are in Place?

☐ Child Tax Credits ☐ Income Support ☐ Universal Credit
☐ Employment and Support allowance ☐ Job Seekers Allowance ☐ Working Tax Credits
☐ Housing Benefit ☐ Personal Independence Payment ☐ Other *(Please specify)*

Social Worker 's Name (Past or Present) **Email:** **Telephone No:**	**Is there a Care Package in place** ☐ Yes ☐ No

Doctor's Name
Address:

Telephone No:

Please provide details of any other medical professional that are currently involved? (Full name and contact details – if any)

Please provide details of any other Voluntary organisations that are supporting you? (Full name and contact details – if any)

7. UNDERSTANDING OUR SERVICES

How did you hear about Headway Essex?

☐ Doctor ☐ Hospital ☐ Internet ☐ News Article ☐ Word of Mouth

DATA PROTECTION

Your private personal information will always be treated with respect. Your information is kept confidential and secure and only used for the purpose of providing you with a service. Everyone working within Headway Essex has a legal duty to keep information about you confidential.

We will not share information unless:

- You give us specific permission
- We have to share by law
- We have good reason to believe that failing to share the information will put you or someone else at risk of serious harm or abuse.
- Our information is essential to prevent, detect, investigate or punish a serious crime.

A full copy of Headway Essex data protection policy is available upon request.

8. DECLARATION AND CONSENT TO BE SIGNED BY THE PERSON BEING REFERRED

In order for Headway Essex to conduct its business and support individuals in relation to their current circumstances, we need permission to obtain, share and hold personal data both internally between departments and external third parties/ agencies.

All personal data will be held on secure servers which can only be accessed by the relevant staff. All laptops have security encryption. Hard copy files will be kept in a locked filing cabinet. No copies of the file will be stored on mobile phones, memory sticks, CDs or any other form of portable device or media.

Personal information may be communicated, verbally by phone or in person, secure email using Headway Essex email addresses or in writing by post or fax.

Information provided will be used anonymously for statistical purposes both internally and to provide external reports to funding providers.

The information may also be used for ABI research purposes. All personal information will be anonymous and confidential.

Personal data will be held and disposed of in accordance with our record keeping policy. A copy of this policy can be obtained upon request.

CONSENT

I hereby consent to Headway Essex's permission to obtain, hold and share personal data in order to conduct its business and provide support whilst using its services.
I hereby consent to an authorised Headway Essex employee to act on my behalf and liaise with the appropriate agencies in relation to my current circumstances:

Tick all that apply.

☐ Social Care	☐ GP
☐ DWP/Benefit Agency Social Care	☐ Friends/Family
☐ Consultant	☐ Other (Please state)
☐ Hospital/Rehabilitation Unit	

Information I do not wish to share (please state):

Person/Agency I do not wish to share information with (Please state):

I reserve the right to withdraw my consent at anytime in writing.

Signature of person being referred _____ Print Name _____

Dated: _____ Review Period: 2 Years

For office use only

Client ID: **CCG Area:**

Referral taken by: **Date:** *Attach this form to the Assessment Form*