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.

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| 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)* |
| How can Headway Essex help, tick all services of interest  Community Support  Day Services  Further Support and Therapies |

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| 1. **YOUR RELATIONSHIP TO THE PERSON BEING REFERRED** | | |
| **Your Name**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **In what capacity do you know the person with the brain injury?** | |
| Spouse or Partner  Family member  Friend | Professional  Other *(please specify)* |
| **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 8, the declaration and consent form. ***(Please fill in the rest of this form.)*** | | |

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| 1. **DETAILS OF PERSON BEING REFERRED** | |
| **Title:** Mr /Mrs/Ms/Miss / Other. **\_\_\_\_\_\_\_\_\_\_\_\_\_**  **First Name** *(known as):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  **Surname:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Current address and postcode:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Telephone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Gender:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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  Black – African | Chinese  Mixed – White/Asian  Mixed – White/Black | | White – British  White – Irish  Other *(please state)* |
| **Religion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Rather not say | |

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| 1. **Details of the Person with Acquired Brain Injury (ABI) who is being cared for** | | | |
| **Name of person with ABI:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Do you have medical confirmation of Acquired brain injury?**  Yes - Please provide a copy for our records  No  **Is the person with ABI aware of this referral?** Yes  No | |
| **Cause of Injury:**  Road Traffic Collision  Fall  Sport / Leisure Accident  Assault / Violence | Stroke  Hemorrhage (bleed)  Meningitis or Encephalitis  Anoxia/Hypoxia (lack of oxygen) | | Tumour removal  Alcohol-related brain injury  Other *(please specify)* |
| **Relationship to the Carer:**  Spouse or Partner Friend  Family member  Other *(please specify)* | | | |

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| 1. **HOW CAN WE HELP?** |
| **What are the current issues/concerns?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **How can Headway Essex help?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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 or Colchester to meet with a worker if required?**  Yes  No |

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| 1. **SUPPORT/SERVICES CURRENTLY IN PLACE** | | | |
| **What benefits are in Place?**  Child Tax Credits  Employment and Support allowance  Housing Benefit | Income Support  Job Seekers Allowance  Personal Independence Payment | | Universal Credit  Working Tax Credits  Other *(Please specify)* |
| **Social Worker ‘s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Telephone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Doctor’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Telephone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Please provide details of any other agencies that are currently supporting you?**  (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)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| 1. **UNDERSTANDING OUR SERVICES** | | | | |
| **How did you hear about Headway Essex?** | | | | |
| Doctor | Hospital | Internet | News Article | Word of Mouth |

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| 1. **DECLARATION AND CONSENT TO BE SIGNED BY THE PERSON BEING REFERRED** |

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| **T:\Headway Logo\New logo\headway logo with 'essex'.jpg**  Headway Essex is committed to protecting your personal data in line with General Data Protection Regulations and in order for Headway Essex to support individuals in relation to their current circumstances, we need permission to obtain, share and hold your personal data both internally between departments and external third parties/ agencies.  Please read the attached Privacy Notice which sets out:   * what personal data Headway Essex processes about you, the reason it processes that personal data, its legal basis for processing that personal data, and how long it will process it for; * who to contact in the event that you have any queries relating to your personal data; * how we use your information; * who Headway Essex may share your personal data with; * the extent to which Headway Essex transfers personal data outside the European Economic Area and * what rights you have in relation to your personal data, and how to exercise them.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  You have the right to withdraw your consent in writing at any time.  Signature of person being referred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| *For office use only*  **Client ID: CCG Area: ……………………………**  **Referral taken by: Date:** *Attach this form to the Assessment Form* |