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 support team on 01206 845945.

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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)* |
| **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 11, the declaration and consent form before sending the completed form. |
| **How can Headway Essex help, tick all services of interest**  Information and Advice Support Services  Psychotherapy  Support Group Meetings |

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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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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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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| 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, 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  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. **PRE-SERVICE ENGAGEMENT RISK ASSESSMENT** |
| In order to ensure the safety and wellbeing of our staff, volunteers and others in our care, please detail any known risks we should be aware of, including risks related to home visits for example:  Previous History Current Risk  Aggressive or violent behavior  Verbal Abuse  Self Harm  Forensic history (e.g. criminal/mental)  Alcohol and/or drug abuse  Pets at Home  Home environment  Other please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. **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. **UNDERSTANDING OUR SERVICES** | | | |
| **How did you hear about Headway Essex?** | | | |
| GP | Other Medical Professional | Internet | News Article |
| Hospital | Social Worker | Social Media | Word of Mouth |

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| 1. **STAYING IN TOUCH** | |
| To subscribe to marketing news about our services and events, simply enter your email address below.  Please review our Privacy Statement – which provides information on how we use and process your data – it’s available at *https://www.headwayessex.org.uk/privacy-statement/.*  You can opt-out at any time by emailing admin@headwayessex.org.uk. | |
| Consent for referrer subscribing | Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Consent for person being referred subscribing | Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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| 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  Department of Work and Pensions  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**IMPORTANT**

Please ensure that you have completed all sections including the consent to process and share information form.

Please send the completed form to:

Service Support Co-ordinator

Headway Essex

6th Floor Wellington House

90-92 Butt Road

Colchester

Essex

CO3 3DA

Email: [abisupport@headwayessex.org.uk](mailto:abisupport@headwayessex.org.uk)

Headway Essex is committed to protecting all personal information collected, for full details please see the Privacy Statement on our website *https://www.headwayessex.org.uk/privacy-statement/*