

## CARER 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 support team on 01206 845945.

1. ARE YOU COMPLETING THIS FORM FOR SOMEONE ELSE?	
<input type="checkbox"/> <b>Yes</b> (please continue to section 2)	<b>Date of Referral:</b> _____
<input type="checkbox"/> <b>No</b> I am applying for Headway Services myself (please complete section 3 onwards)	
<b>Is the person aware of this referral</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <b>IMPORTANT</b> - 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.	
<b>How can Headway Essex help, tick all services of interest</b> <input type="checkbox"/> Information and Advice <input type="checkbox"/> Support Services <input type="checkbox"/> Psychotherapy <input type="checkbox"/> Support Group Meetings	

2. YOUR RELATIONSHIP TO THE PERSON BEING REFERRED	
<b>Your Name</b> _____  <b>Name of your agency (if professional)</b> _____ <b>Address:</b> _____ _____	<b>In what capacity do you know the person with the brain injury?</b> <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Professional <input type="checkbox"/> Family member <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Friend  <b>Telephone No:</b> _____  <b>Email:</b> _____

3. DETAILS OF PERSON BEING REFERRED	
<b>Title:</b> Mr /Mrs/Ms/Miss / Other. _____  <b>First Name (known as):</b> _____  <b>Surname:</b> _____  <b>Current address and postcode:</b> _____ _____	<b>Telephone No:</b> _____  <b>Email:</b> _____  <b>Date of birth:</b> _____  <b>Gender:</b> _____

**4. Details of the Person with Acquired Brain Injury (ABI) who is being cared for**

Name of person with ABI: \_\_\_\_\_

Do you have medical confirmation of Acquired brain injury?

- Yes - Please provide a copy for our records  
 No

Date of Birth: \_\_\_\_\_

Date of injury: \_\_\_\_\_

Is the person with ABI aware of this referral?  Yes  No

Cause of Injury:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Road Traffic Collision   | <input type="checkbox"/> Stroke                          | <input type="checkbox"/> Tumour removal                  |
| <input type="checkbox"/> Fall                     | <input type="checkbox"/> Hemorrhage (bleed)              | <input type="checkbox"/> Alcohol-related brain injury    |
| <input type="checkbox"/> Sport / Leisure Accident | <input type="checkbox"/> Meningitis or Encephalitis      | <input type="checkbox"/> Other ( <i>please specify</i> ) |
| <input type="checkbox"/> Assault / Violence       | <input type="checkbox"/> Anoxia/Hypoxia (lack of oxygen) |  |

Relationship to the Carer:

- |  |  |
|--|--|
| <input type="checkbox"/> Spouse or Partner | <input type="checkbox"/> Friend                          |
| <input type="checkbox"/> Family member     | <input type="checkbox"/> Other ( <i>please specify</i> ) |

**5. HOW CAN WE HELP?**

What are the current issues/concerns?

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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.

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Would you be able to travel to one of our offices, to meet with a worker if required?

- Yes  No

## 6. SUPPORT/SERVICES CURRENTLY IN PLACE

### What benefits are in Place?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Child Tax Credits                | <input type="checkbox"/> Income Support                | <input type="checkbox"/> Universal Credit                |
| <input type="checkbox"/> Employment and Support allowance | <input type="checkbox"/> Job Seekers Allowance         | <input type="checkbox"/> Other ( <i>Please specify</i> ) |
| <input type="checkbox"/> Housing Benefit                  | <input type="checkbox"/> Personal Independence Payment |  |

Social Worker's Name \_\_\_\_\_

Telephone No: \_\_\_\_\_

Email: \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_

### 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)

\_\_\_\_\_

## 7. 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	<input type="checkbox"/>	<input type="checkbox"/>
Verbal Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Self Harm	<input type="checkbox"/>	<input type="checkbox"/>
Forensic history (e.g. criminal/mental)	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol and/or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
Pets at Home		<input type="checkbox"/>
Home environment		<input type="checkbox"/>

Other please state: \_\_\_\_\_

## 8. 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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asian           | <input type="checkbox"/> Chinese             | <input type="checkbox"/> White – British               |
| <input type="checkbox"/> Black - British | <input type="checkbox"/> Mixed – White/Asian | <input type="checkbox"/> White – Irish                 |
| <input type="checkbox"/> Black – African | <input type="checkbox"/> Mixed – White/Black | <input type="checkbox"/> Other ( <i>please state</i> ) |

Religion: \_\_\_\_\_

Rather not say

## 9. UNDERSTANDING OUR SERVICES

### How did you hear about Headway Essex?

- |                                   |   |                                       |  |
|-----------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> GP       | <input type="checkbox"/> Other Medical Professional | <input type="checkbox"/> Internet     | <input type="checkbox"/> News Article  |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Social Worker              | <input type="checkbox"/> Social Media | <input type="checkbox"/> Word of Mouth |

## 10. 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](mailto:admin@headwayessex.org.uk).

Consent for referrer subscribing Email: \_\_\_\_\_

Consent for person being referred subscribing Email: \_\_\_\_\_

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



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.

- |  |   |
|--|---|
| <input type="checkbox"/> Social Care                     | <input type="checkbox"/> GP                   |
| <input type="checkbox"/> Department of Work and Pensions | <input type="checkbox"/> Friends/Family       |
| <input type="checkbox"/> Consultant                      | <input type="checkbox"/> Other (Please state) |
| <input type="checkbox"/> 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 Manager  
Headway Essex  
Woodland Walk  
Colchester  
Essex  
CO4 6DH

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/>