Headway Essex

ABI 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 support team on 01206 845945.

1. ARE YOU COMPLETING THIS FORM FOR SOMEONE ELSE?

☐ **Yes** *(please continue to section 2)* **Date of Referral:** ____________________

☐ **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 ☐ Day Activities

☐ Psychotherapy ☐ Support Group Meetings ☐ Brain Injury ID Card

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)*

____

Telephone No: ____

Address:

____

Email: ____

3. 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: ________________________________

4. CARERS DETAILS (If Applicable)

Title: Mr /Mrs/Ms/Miss / Other. ____________

First Name:________________________ **Surname:** ____________________________

Telephone No: _________________ **Email:** ______________________________

Relationship:
- ☐ Spouse or Partner
- ☐ Family member
- ☐ Professional Carer

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
- ☐ 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)*

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?

____

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

____

Are you 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?

☐ 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 ______________________________
(Past or Present)

Email: ____

Is there a Care Package in place ☐ Yes ☐ No

Telephone No: _____________________________________

Doctor's Name _____________________________________

Telephone No: _____________________________________

Address: ____

____

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. 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: ____

8. LANGUAGE AND CULTURAL BACKGROUND of the person being referred (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

9. 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

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.

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.

☐ 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 Manager
Headway Essex
Woodland Walk
Colchester
Essex
CO4 6DH

Email: 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/*