If you require any help to complete this form, please contact us and someone will get back to you: 01325 370563

1. ARE YOU COMPLETING THIS FORM ON BEHALF OF 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 ☐ Family member ☐ Professional ☐ Other (please specify)……
Name of your agency: (if professional) **Address:**	**Contact telephone number:** **Email:**

3. DETAILS OF PERSON BEING REFERRED		
Title: Mr/Mrs/Ms/Miss **First Name:**		**Surname:**
Date of birth:	**Gender:**	**Marital Status:**
Current address and postcode: **Contact telephone number:** **Email:**		

4. DETAILS OF THE ACQUIRED BRAIN INJURY (ABI)
(Please provide as much detail as possible)

Date of injury:

Cause of injury:

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

Any other injuries sustained at the time of incident:

Please provide details of existing difficulties you feel you have as a result of your brain injury:

- ☐ Epilepsy
- ☐ Visual
- ☐ Hearing
- ☐ Taste/Smell
- ☐ Education/Information
- ☐ Movement/Mobility
- ☐ Speech & language
- ☐ Behaviour
- ☐ Emotions/Mood
- ☐ Memory
- ☐ Attention/Concentration
- ☐ Problem Solving
- ☐ Pain
- ☐ Self-awareness/Insight
- ☐ Other (please specify) ……

Reasons for Referral:

- ☐ Social/Community support
- ☐ Advice/Advocacy/Financial support
- ☐ Education regarding brain injury
- ☐ Vocational Support
- ☐ Other (please specify)

5. Next of kin details:

We support both brain injury survivors & their families. If you are happy to then please provide us with the details of your next of kin who we may contact for further information.

Name: **Relationship:** (ie partner, daughter, friend) **Contact Number:**

In case of an emergency please provide us with GP details.

GP Name:
Address:
Telephone Number:

Please provide details of any other medical professionals that are currently involved? (full name and contact details, if any)

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

In order for Headway Darlington & District to support individuals in relation to their current circumstances, we require permission to obtain, share and hold personal data both internally and with external third parties/agencies when required.
All personal data will be held on secure servers which can only be accessed by the relevant staff. Hard copy files will be kept in a locked filling cabinet. None of your information will be stored on mobile phones, memory sticks or any other form of portable device or media.
Personal information may be communicated, verbally by phone or in person. Secure email using Headway Darlington & District email addresses or in writing by post.
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 Darlington & District permission to obtain, hold and share personal data in order to provide support whilst using its services.
I hereby consent to an authorised Headway Darlington & District employee/volunteer to act on my behalf and liaise with the appropriate agencies in relation to my current circumstances:

Tick all that apply.

- ☐ Social Care
- ☐ DWP/Benefit Agency Social Care
- ☐ Consultant
- ☐ Hospital/Rehabilitation Unit
- ☐ GP
- ☐ Friends/Family
- ☐ Other (please specify)

Person/Agency I do not wish to share information with (please state):
I reserve the right to withdraw my consent at any time in writing.

Signature of person being referred: _____
Print Name: _____
Date:

For office use only
Client ID: **CCG Area:**
Referral taken by: **Date:** **Interview arranged for:**