REFERRAL FORM FOR SERVICES

Headway East London is a charity which supports people affected by brain injury. This includes provision of specialist services for brain injury survivors, their friends, families and carers.

For full information about our services please call the office on 0207 749 7790 or visit our website: headwayeastlondon.org

FUNDING FOR HEADWAY SERVICES

Services	**Price**
Casework/ Family Support	Free to access – Short term pieces of information, advice and advocacy and family support groups are free to access
Day Services (*Including Young People's Group)*	£89.50 per day placement (excluding transport)
Community Support Worker Service	Standard rate - £20.70* p/h (inclusive of reasonable expenses) Higher rate - £22.20* p/h for clients with complex needs (inclusive of reasonable expenses) **A decision upon which rate will be charged will be made at assessment. Minimum service provided, 4 hours per week.*
Neurological Therapy Service	Price on application

NB: All prices are reviewed annually and are subject to change.

REFERRAL CRITERIA

- Anyone can make a referral.
- Referrals **must** be for someone who has had an acquired brain injury (ABI) and is over 16 years old.
- Headway East London does not offer services to people who have a progressive illness or who have had a brain injury at birth. If the person referred sustained an injury in childhood Headway East London reserves the right to carry out an extended assessment or suggest appropriate alternative services.

- Headway East London is only able to offer placements/services to people with high care needs if we are confident we will be able to meet those needs.

To be referred you **must** live in our catchment area which includes the following London Boroughs:

Barking & Dagenham	Haringey	The City
Camden	Havering	Tower Hamlets
Enfield	Islington	Waltham Forest
Hackney	Newham	Westminster
	Redbridge	

Referrals **must** be accompanied by at least one of the following documents about the person's injury:

- **Hospital Discharge Report**
- **Neuropsychology Assessment**
- **Therapy/Rehabilitation Discharge Report**
- **Report from Current Therapist**
- **Social Services Needs Assessment**

If you are making a referral for a paid service, please find out **who will be paying for the service.**

- If Social Services will be paying for the service, you **must** make a referral to their access team clearly stating the cost of the service and requesting they carry out a Care Needs Assessment. Please indicate the date of your Social Services referral.
- If the cost of the service is to be paid by the NHS this form **must** be accompanied by confirmation of funding from the Clinical Commissioning Group/Health Commissioning Services

If you are **not** making this referral in a professional capacity and are referring yourself or someone in your family we can help you with making these arrangements; please get in touch.

REFERRAL INFORMATION

Referral date	

Referral Name	
Date of Birth	
Address	
Phone	
Email	
National Insurance Number	
Local Authority	

Referred by (name)	
Relationship/Role	
Address	
Phone	
Email	

Name of main carer/ next of kin	
Relationship	
Address	
Phone	
Email	

Does the referral have recourse to public funds	Yes or No (please circle)

Has a care assessment been completed?	Yes or No (please circle) Date requested or completed:
Who will be paying for the service/s?	
Name	
Address	
Phone	
Email	

Social Worker (current/previous)	
Address	
Phone	
Email	

Name of Current or Previous Therapist	
Type of Therapy	
Address	
Phone	
Email	

Name of GP	
GP Practice Name	
Address	
Phone	
Email	

DETAILS OF INJURY

Date of injury/diagnosis:

Name of hospital attended:

Dr / Consultant / Neurosurgeon :

Acquired Brain Injury:

☐ **Vascular, e.g. stroke, haemorrhage, aneurism** (please give details)

☐ **Viral, e.g. meningitis, tuberculosis** (please give details)

☐ **Other, e.g. tumour, infection, chronic alcoholic** (please give details)

Traumatic Brain Injury:

☐ **RTA** (please give details)

☐ **Violence** (please give details)

☐ **Other, e.g. fall, penetrating injury** (please give details)

Please mark any of the following areas of function the person is having difficulty with as a consequence of their injury:

☐ **Epilepsy**
☐ **Movement/Mobility**
☐ **Vision**
☐ **Hearing**
☐ **Taste/Smell**
☐ **Speech and language**
☐ **Behaviour**
☐ **Emotions**
☐ **Memory**
☐ **Attention/concentration**
☐ **Self-awareness/Insight**
☐ **Problem solving**
☐ **Pain**
☐ **Transfers**
☐ **Fatigue**
☐ **Other difficulties**

(Please give details):

Medical condition:

Please give a brief description of any other significant medical condition:

☐ **Diabetes** (please give details)

☐ **Cancer** (please give details)

☐ **Kidney disease** (please give details)

☐ **Allergies** (please give details)

☐ **Other** (please give details)

RISKS

Please provide details of any risks – including risks related to home visits (e.g. pets at home, state of home)

☐ **History of self-harm** (please give details)

☐ **Current self-harm** (please give details)

☐ **Suicidal ideation** (please give details)

☐ **Previous suicide attempt** (please give details)

☐ **Forensic History** (please give details)

☐ **Previous harm to others** (please give details)

☐ **Current risk to others** (please give details)

SERVICES

What is the primary reason for this referral?

If you know please mark which service this referral is for. More than one service can be selected:

FREE SERVIVES

Casework ☐

Family Support ☐

PAID SERVICES

Day Service ☐

Young People's Group ☐

Community Support Worker Service ☐

Neurological Therapy Service (Fees apply for all therapy services)

- **Physiotherapy** ☐
- **Occupational Therapy** ☐
- **Psychotherapy** ☐
- **Neuropsychology** ☐
- **Complementary Therapies (Inc. Craniosacral therapy)** ☐

Don't Know ☐

IMPORTANT

We cannot accept incomplete referrals. Please ensure that you have completed all sections including the consent to share information.

If you are self-referring or referring someone else in a non-professional capacity i.e. family member or friend, you do not have to have all of these details and or documents. Provided your referral includes consent to share information we can find out these details at a later stage.

REFERRAL CHECKLIST

- ☐ **Referral Form**
- ☐ **Discharge Report/Neuropsychology Assessment**
- ☐ **Social Services Care Needs Assessment**
- ☐ **Social Services Care Plan**
- ☐ **Ethnic Monitoring Form (see below)**
- ☐ **Consent to Share Information Form (see below)**

Please send the completed form to:

Headway East London
Bradbury House
Timber Wharf, Block B
238-240 Kingsland Road
London E2 8AX

Tel: 020 7749 7790

Fax: 020 3582 4688

Email: info@headwayeastlondon.org

ETHNIC MONITORING FORM

What is your ethnic group?

Choose ONE section from A to E, and then tick the appropriate box to indicate the cultural background of the person being referred.

A. White

- ☐ British
- ☐ Irish
- ☐ Any other White background, please state:

B. Mixed

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed background, please state:

C. Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background, please state:

D. **Black or Black British**

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background, please state:

E. Chinese or other ethnic group

- ☐ Chinese
- ☐ Any other, please state:

CONSENT TO SHARE INFORMATION FORM

To help Headway East London support you more effectively, we may be required to provide information to and receive information from other parties involved in supporting you.

These might include, for example, your Local Authority, Hospital staff, GP, Therapy Team, Social Worker and Housing Support Officer.

This helps everyone work together.

Wherever possible we will ask your permission to pass information on.

All information will be held in the strictest confidence and will only be available to staff and volunteer helpers on a 'need to know' basis. Personal details may be stored on a database.

I give consent for Headway East London staff to communicate with all parties supporting me, as appropriate to my needs.

Date _____

Signature _____

Printed Name _____

Date of Birth _____

Address _____

_____

_____

Witness / Carer signature _____

Printed Name _____

Relationship to person _____