**REFERRAL FORM FOR COMMUNITY BRAIN INJURY SERVICE (CBIS)**

The information requested is essential to help us to determine the appropriateness of our service and prioritise those referred. Please complete the form in full as incomplete referrals will not be accepted and will result in delay.

Please see the referral criteria below before completing the referral form:

**REFERRAL CRITERIA - Please complete the following checklist.**

**Only continue with referral if you answer Yes to ALL questions.**

Has the person had a brain injury (excluding stroke)? Yes/No

Is the person 18 or over? Yes/No

Do they live in Enfield? Yes/No

Do they have an Enfield GP? Yes/No

Has the person agreed to this referral? Yes/No

**We are unable to accept individuals who:**

* Have a progressive illness or who have had a brain injury at birth. If the person referred sustained an injury in childhood the Community Brain Injury Service reserves the right to carry out an extended assessment or suggest appropriate alternative services.
* Have a diagnosis of Stroke including sub-arachnoid haemorrhage. Please direct all relevant referrals to the Enfield Stroke service.

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**

If you are **not** making this referral in a professional capacity and are referring yourself or someone in your family we can support you in this process; please contact the team on 020 7749 7790.

**Please send the completed form to:**

Laura Jacobs

Headway East London,

Timber Wharf,

238-240 Kingsland Road,

London,

E2 8AX

Email: [laura.jacobs@nhs.net](mailto:laura.jacobs@nhs.net)

|  |  |
| --- | --- |
| **Referral Date** |  |
| **Name** |  |
| **Date of Birth** |  |
| **NHS number** |  |
| **Address** |  |
| **Phone** |  |
| **Email** |  |

|  |  |
| --- | --- |
| **Referred by (name)** |  |
| **Relationship/Role** |  |
| **Address** |  |
| **Phone** |  |
| **Email** |  |

|  |  |
| --- | --- |
| **Name of GP** |  |
| **GP Practice Name** |  |
| **Address** |  |
| **Phone** |  |
| **Email** |  |

|  |  |
| --- | --- |
| **Name of main carer/next of kin** |  |
| **Relationship** |  |
| **Address** |  |
| **Phone** |  |
| **Email** |  |

|  |  |
| --- | --- |
| **Current location** |  |
| **Address (including ward if relevant)** |  |
| **Phone** |  |
| **Date of discharge (if relevant)** |  |

|  |  |
| --- | --- |
| **Living alone** | **YES / NO** |
| **If no, please give details** |  |
| **Ability to travel to Brain Injury Clinic** | **YES / NO** |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and contact of professionals and services involved:** | | | |
|  | **NAME** | **TELEPHONE** | **EMAIL** |
| **Social Worker** |  |  |  |
| **OT** |  |  |  |
| **Physiotherapist** |  |  |  |
| **SALT** |  |  |  |
| **Neuropsychologist** |  |  |  |
| **Neurologist** |  |  |  |
| **Day Service** |  |  |  |
| **Mental Health Services** |  |  |  |
| **Other** |  |  |  |
|  |  |  |  |

**Diagnosis**

**Date of injury/onset:**

**Diagnosis including scan results:**

**Name of hospital attended:**

**Consultant / Neurologist:**

**MEDICAL HISTORY (including medication)**

**Medical Disorders: *(please tick)* Medical/Surgical Procedures:**

 Diabetes  Gastrostomy tube

 Heart failure  Nasogastric tube

 Hypertension  Tracheostomy tube

 Epilepsy  Ventricular shunt

 MRSA positive  Urinary catheter

 HIV positive  Suprapubic catheter

 Known hepatitis  Other procedure (state)

 Other infectious or communicable disease

**functional Ability PRIOR TO BRAIN INJURY OR FOR OLDER INJURIES, LAST 12 MONTHS (Mobility, Transfers, Activities of Daily Living, Occupation)**

**Social Situation and Home Environment**

**Care Package: Yes/No. Details:**

**Is this adequate to meet needs: Yes/ No**

**Comment:**

**SUMMARY OF IMPAIRMENTS - please complete with as much information as you can**

|  |  |
| --- | --- |
| **Physical (motor and sensory)** |  |
| **Sensory (vision, hearing, smell, sensation, pain)** |  |
| **Bladder/Bowel/Sexual Functioning** |  |
| **Pressure areas** |  |
| **Cognition (memory, insight / self-awareness, attention / concentration)** |  |
| **Psychosocial (Mood, interaction)** |  |
| **Behaviour** |  |
| **Sleep, Energy and Fatigue** |  |
| **Communication** |  |
| **Swallowing** |  |
| **Any other information** |  |

**current functional status**

|  |  |
| --- | --- |
| **Mobility (indoor/outdoor/stairs/**  **bed mobility):** |  |
| **Functional Transfers:** |  |
| **Personal ADL (wash, dress, toileting, feeding)** |  |
| **Specialist Seating needs:** | **Yes/ No If yes, supplied by:**  **Wheelchair Type:**  **Seating Tolerance:** |
| **Splints/Casts:** | **Yes/No If yes, supplied by:**  **Regime:** |
| **Carer/ Childcare commitments** |  |
| **Vocational situation** |  |
| **Community participation** |  |

**reason for referral (include therapy goals)**

**PATIENT AND FAMILY EXPECTATIONS**

**RISKS**

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

**Current / History of self-harm? Yes / No. If yes, give details:**

**Suicidal ideation / Previous suicide attempt? Yes / No. If yes, give details:**

**Forensic History? Yes / No. If yes, give details:**

**Current risk / previous harm to others? Yes / No. If yes, give details:**

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

**Physiotherapy**

**Occupational Therapy**

**Psychological Therapies (including Neuropsychology)**

**Don’t Know**

**IMPORTANT**

**We cannot accept incomplete referrals. Please ensure that you have completed all sections including the consent to process & 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**

**Supporting documents (eg: Discharge Report/Neuropsychology Assessment)**

**Ethnic Monitoring Form (see below)**

**Consent to Share Information Form (see below)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OUTCOME OF REFERRAL (f*or completion by Headway team only)***

*Accepted: Yes/No*

*Pathway: Rehab/DM*

*If not accepted state reasoning:*

*Other notes (e.g. signposted to X, invite to join support group):*

**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.

1. **White**

British

Irish

Any other White background, please state:

1. **Mixed**

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed background, please state:

1. **Asian or Asian British**

Indian

Pakistani

Bangladeshi

Any other Asian background, please state:

1. **Black or Black British**

Caribbean

African

Any other Black background, please state:

1. **Chinese or other ethnic group**

Chinese

Any other, please state:

     **CONSENT TO PROCESS & SHARE INFORMATION FORM**

To help the Community Brain Injury Service (CBIS) to support you more effectively, we may be required to provide information to, and receive information from, other parties involved in supporting you. 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 security cleared staff and/or volunteers on a ‘need to know’ basis. Personal details are stored on Secure, Data Protection compliant databases.

**By signing this referral / consent form, you are positively “opting-in” for CBIS to process relevant personal information required to provide support/ a service.**

You are able to withdraw consent at any stage by explicitly i.e. clearly & definitively, communicating this to CBIS. Withdrawal of consent may affect our ability to make contact with third parties regarding your support, and may affect our ability to support you in certain cases.

As part of Headway East London, information regarding CBIS’s Data Protection & Privacy Policy are below. For full details please see our website <http://headwayeastlondon.org/page/privacy-policy/>

**To assist with my support, I consent to CBIS storing & processing my personal information using their secure physical & online systems (accessible to relevant security cleared CBIS staff involved in my support) in line with Headway East London’s Data Protection Policies (detailed on the sheet below and on Headway East London’s website)**

**To assist with my support, I consent to CBIS sending and receiving information to & from relevant agencies/professionals involved in, or required to be involved in, my support. This may include (but is not limited to) My Local Authority, Social Workers, Hospital Staff, My GP, Therapy personnel, Housing Staff, Benefit Agencies and Other Relevant statutory agencies/personnel**

**I do not consent to CBIS sending and receiving information to/from the following:**

|  |  |
| --- | --- |
| **(Please state):** |  |
| Referee Signature |  |
| Printed Name |  |
| Date of Birth |  |
| Address |  |
|  |  |
| Date: |  |
| Witness / Carer signature |  |
| Printed Name |  |
| Relationship to person |  |

**Information Regarding Headway East London’s (HEL) Data Protection & Privacy Policy**

**What Lawful Basis does HEL utilise to process data?**

HEL predominantly utilises Consent, Contract and Legitimate Interests to process personal data**. By signing a HEL referral / consent form and/ or requesting support from HEL, you are positively “opting-in” for us to process the relevant personal information required for us to provide support/ a service.**

* The personal data collected relating to **non-funded members** (Casework, Family Support) is done so based on the lawful basis of Legitimate Interests and/or Consent
* The personal data collected relating to **funded members** (Day Service, Support Work, Therapies) is done so based on the lawful basis of Contract

As the nature of our work involves medically related conditions, HEL processes special category data (health records). HEL satisfies the additional condition (h) required under article 9 of GDPR for processing this data.

**What personal data does HEL collect?**

Depending on what service/project/information you receive from HEL, this will determine what personal data is collected. This may be different for a funded service and a non-funded service. The HEL referral form covers the majority of headings of data that is collected.

**What do we use your personal data for?**

Depending on what service/project/information you receive from HEL, this will determine what we use your personal data for, why and for how long. Predominantly information is used for different purposes throughout someone’s relationship with HEL. This may be to verify someone is in our catchment, verifying the condition is within our remit, assessing risk levels to self & others etc., having information about support needs etc.

**Where is the data stored and who has access?**

HEL uses appropriate technical and organisational measures including secure paper filing systems, security tiered software, and cloud based Management systems to process personal data. Data is predominantly stored on GDPR compliant databases including Charitylog and SharePoint. These database have tiered security levels and staff with relevant security level clearance will be able to access details on these databases.

**Is this data being shared with 3rd parties? (i.e. organisations external to HEL)**

There may be situations when it is necessary to share personal information with third parties. This may be to allow us to support you, and/or to get other organisations involved in supporting you. If written consent is received and relevant support is required, data may be sent to, and received from, 3rd party agencies already involved, or required to be involved with supporting someone.

**How long do we keep personal data? What is the policy on data deletion?**

Information is retained as long as a service contract is in place and/or ongoing support is occurring. If there has been inaction with a person for a period of 6 years the information with be archived and/or deleted to retain only non-identifiable information and retain the statistical information.

**Your Data Protection Rights**

Headway East London (HEL) takes our responsibilities regarding the security of personal information seriously and strives to be open, transparent and proactive in every aspect of how we manage data. HEL is fully committed to adhering to the following rights for individuals; you have the right: to be informed, of access, to rectification, to erasure, to restrict processing, to data portability, to object.

**I have more questions! I’m not clear! How can I find out more?**

For a comprehensive breakdown of all the information collected by HEL, and a justification of why, please see the relevant tab on the HEL Data Mapping Excel sheet which can be found on our Privacy Policy page on our website. If you wish to have more information on ways HEL processes data, or to assist with making a choice about “opting-in”, please request this from the HEL Data Protection Officer through a member of staff, calling 020 7749 7790 or emailing [info@headwayeastlondon.org](mailto:info@headwayeastlondon.org)