Kemsley, National Centre for Brain Injury Rehabilitation Referral Form

St Andrew's HEALTHCARE

PLEASE COMPLETE ALL SECTIONS AND RETURN THE FORM TO THE ADDRESS DETAILED ON PAGE 6

REFERRER'S DETAILS	
NAME OF REFERRER:	
DESIGNATION:	DATE OF REFERRAL:
EMAIL ADDRESS:	CONTACT PHONE NUMBER:
NAME OF ORGANISATION: CONTACT ADDRESS: POSTCODE:	
REASON FOR REFERRAL:	

DETAILS OF PERSON REFERRED	
SURNAME:	SURNAME AT BIRTH:
FORENAMES:	DATE OF BIRTH: (dd/mm/yy)
PATIENT'S CURRENT ADDRESS/PLACEMENT (State if living in own home / family home): POSTCODE:	TELEPHONE:
CONSULTANT IN CHARGE: (RMO)	CARE COORDINATOR (NAMED NURSE):
PATIENT'S LAST KNOWN HOME ADDRESS: POSTCODE:	TELEPHONE:
OCCUPATION:	MARITAL STATUS:
LEGAL STATUS: (Informal/detained)	ETHNIC GROUP:
RELIGION:	SOCIAL WORKER: TELEPHONE:

CONTINUED…

LAST KNOWN GP's NAME:

GP ADDRESS:

POSTCODE: **TELEPHONE:**

NEXT OF KIN (NAME):

ADDRESS:

POSTCODE: **TELEPHONE:**

FAMILY SITUATION & INVOLVEMENT (Include Contact Details)

NAMES & DATES OF OTHER PLACEMENTS SINCE INJURY:

ARE THE FOLLOWING PEOPLE AWARE OF THIS REFERRAL:
(Circle as appropriate)

1. **PERSON REFERRED - YES / NO**
2. **FAMILY - YES / NO**
3. **FUNDING AUTHORITY - YES / NO**

ALTERNATIVE PLACEMENTS (Has this person been referred to other placements within the last 3 months? If so where, when and what is the status of the referral?)

LEGAL FACTORS - SOLICITORS NAME:

ADDRESS:

POSTCODE: **TELEPHONE:**

BRAIN INJURY HISTORY		
DATE, CAUSE AND NATURE OF BRAIN INJURY:		
DURATION OF UNCONSCIOUSNESS / PTA:		
OTHER INJURIES SUSTAINED:		
MEDICAL HISTORY PRIOR TO BRAIN INJURY:	**PHYSICAL e.g. ASTHMA, DIABETES:**	
	MENTAL HEALTH e.g. DEPRESSION:	
MEDICAL HISTORY FOLLOWING BRAIN INJURY:	**PHYSICAL e.g. SEIZURES**	
	MENTAL HEALTH	
CURRENT MEDICATION:		
KNOWN ALLERGIES:		

AGGRESSION – GIVING EXAMPLES & FREQUENCY WHERE POSSIBLE	
VERBAL AGGRESSION:	
PHYSICAL AGGRESSION AGAINST OBJECTS:	
PHYSICAL AGGRESSION AGAINST SELF:	
PHYSICAL AGGRESSION AGAINST OTHER PEOPLE:	

OTHER RISK BEHAVIOURS OR ISSUES	
PLEASE SEND CURRENT RISK ASSESSMENT OR GIVE INFORMATION REGARDING RISK BEHAVIOURS IN TERMS OF THEIR FREQUENCY, SEVERITY AND INCLUDE ANY DETAILS ON WHETHER THE BEHAVIOURS ARE CURRENT OR PRECEDE THE HEAD INJURY AND WHETHER THERE IS PRE-MEDITATION. THIS WILL ASSIST US IN MAKING SAFE AND INFORMED DECISIONS IN TERMS OF THEIR CLINICAL NEEDS AND IN CONSIDERING THE SUITABILITY OF OUR CLINICAL AREAS	
SUICIDE/SELF HARM:	
VULNERABILITY:	
SEXUAL DISINHIBITION:	
WANDERING / ABSCONSION:	
BULLYING / INTIMIDATION:	
SUBSTANCE / ALCOHOL MISUSE:	
ARSON:	
RISKS ARISING FROM PHYSICAL HEALTH:	

BASIC FUNCTIONAL LIVING SCALE (PLEASE PROVIDE EXTRA DETAILS AS APPROPRIATE)		
CONTINENCE		**ADDITIONAL INFORMATION**
Fully Independent	**Y / N**	
Urinary Incontinence	**Y / N**	
Faecal Incontinence	**Y / N**	
WASHING, DRESSING AND GROOMING ACTIVITIES		**ADDITIONAL INFORMATION**
Fully Independent	**Y / N**	
Requires Assistance / Intervention	**Y / N**	
EATING & DRINKING SKILLS		**ADDITIONAL INFORMATION**
Fully Independent	**Y / N**	
Requires Assistance / Intervention	**Y / N**	
OTHER RELEVANT DETAILS E.G. NASO-GASTRIC TUBE, PEG, TEXTURED DIET OR DYSPHAGIC:		
MOBILITY		**ADDITIONAL INFORMATION**
Fully Independent	**Y / N**	
Requires Assistance / Intervention	**Y / N**	
Hoist Required	**Y / N**	
OTHER EQUIPMENT REQUIRED (PLEASE SPECIFY)		

CURRENT ABILITIES / DIFFICULTIES (PLEASE PROVIDE EXTRA DETAILS AS APPROPRIATE)	
COMMUNICATION DIFFICULTIES:	
MEMORY:	
HEARING:	
VISION:	

OTHER INFORMATION
PLEASE PROVIDE DETAILS ANY OTHER RELEVANT INFORMATION HERE:

FUNDING SOURCE / RESPONSIBLE PCT (IF KNOWN)	
ORGANISATION:	
CONTACT:	
ADDRESS: **POSTCODE:**	
TELEPHONE:	
EMAIL:	

HOW DID YOU HEAR ABOUT KEMSLEY / ST ANDREW'S HEALTHCARE (Please tick)			
CURRENT IN PATIENT:		**PREVIOUS REFERRAL:**	
JOURNALS/ADVERT:		**WEBSITE:**	
NEWSLETTER:		**CONFERENCE:**	
BROCHURE:		**OTHER:**	

PLEASE RETURN THIS COMPLETED FORM TO…
THE BUSINESS ADMINISTRATOR **ST ANDREW'S HEALTHCARE - KEMSLEY,** **BILLING ROAD, NORTHAMPTON NN1 5DG** **TEL: 01604 616454** **FAX: 01604 616231** **www.stah.org**
ANY COMMENTS THAT YOU WOULD LIKE TO MAKE ABOUT THIS FORM, IN PARTICULAR ITS EASE OF COMPLETION, WOULD BE APPRECIATED. **THANK YOU FOR YOUR ASSISTANCE**

PLEASE SEND CARE PLANS AND ANY OTHER RELEVANT REPORTS WITH THIS REFERRAL FORM.

WE WILL ACKNOWLEDGE THE REFERRAL ON RECEIPT AND ADVISE YOU OF THE NEXT STEP WITHIN TEN WORKING DAYS.

THANK YOU FOR COMPLETING THIS REFERRAL FORM.