ACQUIRED BRAIN INJURY IRELAND

Referral Form

PLEASE USE BLOCK CAPITALS AND FILL IN AS MUCH DETAIL AS POSSIBLE.

PERSONAL DETAILS

First Name: ____________________________

Surname: ____________________________

Maiden Name: ____________________________

Address: ____________________________

____

____

Home Tel Number: ________________________

Mobile Number: ________________________

Email: _____________________________________

Date of Birth: / /

Age: _____ yrs

Gender:__________

Male __ Female ____

Health Service Executive Area:

____

Country of Origin:

____

Referred for:

Residential Rehab ☐

Transitional Rehab ☐

Community Rehab ☐

Case Management ☐

Day Rehabilitation ☐

Reason for Referral: *Please indicate clearly your reason for referral:*

CONTACT PERSONS

General Practitioner:

Name: ____________________________

Address: ____________________________

____

Tel No: __________ Mobile No: ________________

Next of Kin 1:

Name: ____________________________

Address: ____________________________

____

Tel No: _______________ Mobile No:__________________

Relationship to person referred_________________________

Next of Kin 2:

Name: ____________________________

Address: ____________________________

Tel No: _____________ Mobile No:____________________

Relationship to person referred_________________________

Main Carer / Contact Person *(if different to NOK)*:

Name: ____________________________

Address: ____________________________

____

Tel No: _____________ Mobile No:____________________

Relationship to person referred_________________________

SOCIAL INFORMATION

Family Support:	Parent ☐	Children ☐	Spouse ☐	Partner ☐	Siblings ☐	Other ☐
Relationships:	Single ☐	Married ☐	Co-habiting ☐	Separated ☐	Divorced ☐	Widow ☐
Living Situation:	Alone ☐	With Parents ☐	With Partner ☐	Hospital ☐		
	Prison ☐	Residential ☐	Care Home ☐	Homeless ☐		

Children: Number of Children over 18yrs ____ Number of Children under 18yrs ____

Employed at Time of Injury: Yes ☐ No ☐

Type and Duration of Employment: ____

FINANCIAL AND HOUSING INFORMATION

State Medical Card ☐
Medical Card No: ________________________

Local Authority List ☐
Housing Registration No: ________________________

Disability Allowance ☐
Long Term Illness Book ☐
Pension ☐
Ward of Court ☐
Court Case Pending ☐

DETAILS OF ACQUIRED BRAIN INJURY (ABI)

Date of Injury: / /

Cause of Injury: ____

Traumatic Brain Injury:

Road Traffic Accident:
☐ Vehicle Driver
☐ Vehicle Passenger
☐ Bicycle
☐ Motorcycle
☐ Pedestrian

Fall: ☐

Other: __________________________

Assault:
☐Gunshot
☐Other Weapon
☐Non-weapon Assault

Sporting Accident: ☐

Non Traumatic Brain Injury:

Stroke:
☐ Ischaemic Stroke
☐ Intracerebral haemorrhage
☐ Subarachnoid haemorrhage

Infection:
☐Meningitis
☐Encephalitis
☐Other

Anoxia/ Hypoxia: ☐
(lack of oxygen)
Other: ______________________

Eating Disorder: ☐
Toxic or Metabolic Insult: ☐

Overdose: Accidental ☐
Overdose : Intentional ☐

Multiple Sclerosis ☐
Korsakoff's Disease ☐

Tumour: ☐
Post-Surgical Damage: ☐
(e.g. post tumour removal)

PRIMARY DIFFICULTIES:

Please rate the 8 domains in terms of impact on functioning with 3 being the area of most impact, 2 being an area of significant impact and 1 being a minor impact area for this person.

	Domain	Examples
☐	Thinking Skills:	Memory, Concentration, Planning, Organising, Decision Making, Orientation, Insight.
☐	Communication:	Language Expression, Language Comprehension, Turn Taking, Social Skills.
☐	Behaviour:	Impulsive, Disinhibited, Irritable, Aggressive, Passive.
☐	Mood:	Tearfulness/Depression, Mood Swings, Worry/Anxiety, Reduced Confidence, Suicidal.
☐	Physical:	Wheelchair, Poor Mobility, Hemiparesis, Weakness, Balance, Fatigue, Pain, Seizures, Diabetes.
☐	Sensory:	Problems With Eyesight, Hearing, Sensitivity to Touch, Sense of Smell, Sense of Taste.
☐	Basic Care:	Incontinence, Personal Hygiene, Toileting, Self-Medication, Independence, Eating & Drinking.
☐	Social:	Reduced Social Network, Relationship Difficulties, Sexual Difficulties, Isolation, Lack of Meaningful Activity / Supports, Lack of Structure / Routine.

HISTORY OF THE ACQUIRED BRAIN INJURY:

USE ADDITIONAL PAGE IF REQUIRED

Hospital Admissions & Dates

Hospital Name:___________________________ Admission date: / / Discharge date: / /

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Hospital Name: ___________________________ Admission date: / / Discharge date: / /

Consultants attended

Name:___________________________ Hospital: ___________________________

Name: ___________________________ Hospital: ___________________________

Name: ___________________________ Hospital: ___________________________

Name: ___________________________ Hospital: ___________________________

PAST & CURRENT SERVICES ATTENDED

Past Services Attended (e.g. Speech & Language Therapy, Physiotherapy, Occupational Therapy, Psychology)

Current Services Attended (e.g. Speech & Language Therapy, Physiotherapy, Occupational Therapy, Psychology)

Please Specify Any On-Going Therapy

Current Medication *Please write medications legibly in BLOCK CAPITALS*

MEDICAL INFORMATION

Previous History of Head Injury Yes ☐ No ☐ | Epilepsy Prior To Brain Injury Yes ☐ No ☐

Previous Medical History / Illness / Hospitalisation: (are there any degenerative / progressive / deteriorating conditions)

Previous Psychiatric History / Mental health difficulties / Treatment / Hospitalisation:

Names of Doctors and/or Hospitals Attended:

HISTORY OF SUBSTANCE ABUSE OR ADDICTION

Alcohol ☐ Drugs ☐ Gambling ☐ Other ☐ - Please Specify: ______________________________

Prior Treatment: Yes ☐ No ☐

Program Name: ____________________________ Admission date: / / Discharge date: / /

Program Name: ____________________________ Admission date: / / Discharge date / /

Program Name: ____________________________ Admission date: / / Discharge date: / /

Program Name: ______________________________Admission date: / / Discharge date: / /

Any Current Treatment or Support From Drug And Alcohol Services: Yes ☐ No ☐

IF ABSTINENT - LENGTH OF ABSTINENCE ____

PROFESSIONAL AGENCIES / SERVICES CURRENTLY INVOLVED

Are you in receipt of a service at present from the HSE, such as Public Health Nurse, Case Manager etc or from any other organisation? If so, please list:

REFERRAL DETAILS - THIS MUST BE FILLED IN

Date of Referral: / /

Name of person completing this form: ____

Relationship to person referred: ____

Agency where relevant? ____

Address:____

Email: ______________________________ Telephone: __________________

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Consent Forms Received Yes ☐
Referral Summary Complete Yes ☐
Initial Assessment Complete Yes ☐
Referral Agent Notified Decision Yes ☐

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