HEADWAY SOMERSET **Form HS 201b**

REFERRAL INFORMATION

This form is for completion when requesting support from Headway Somerset, for assessment or service allocation. The referrer is requested to provide as much information as possible in the boxes below. Thank you.

Client's Personal Details

Name:

Address: DOB: Tel No:

Marital Status:

Next of Kin

Name:
Relationship:
Tel No:
Address:

Contact/ Carer (if different from NOK)

Name:
Relationship: Tel No:

Address:

G.P.

Name:
Tel No:
Address:

Hospital Liaison worker

Name:
Tel No:

Which ward/ hospital

Type of Referral

Self	Adult Social Care	GP	Hospital	SOMPAR	Other

Locality

South Somerset

Mendip

North Somerset

Sedgemoor and Taunton

West Somerset

Cause of Head Injury

Date acquired:

Referred by

Name

Tel. No:

Presenting Difficulties (Please comment)

Cognitive (thinking, memory, planning, tiredness, understanding, concentration and use of language)**:**

Emotions:

Feeding:

Mobility:

Behaviour changes:

Senses (Sight, hearing, touch, smell, taste, muscle sense, perception)**:**

Epilepsy:

Relationships:

Other Problems (include any allergies)**:**

Are Adult Social Care already involved

Yes - "Your Care Needs" form completed DP agreed or Care order received/in progress

No Would the client/carer like Headway Somerset to make a referral to Adult Social Care on their behalf

Yes/NO

If yes – Date call made to Somerset Direct and name of person spoke to

Has a Disclosure of Information form been signed

Details of Initial Visit:

Visiting Manager/support worker Name Tel no	**Date:**
Information provided on Brain injury & Headway Somerset	**YES / NO**
Function assessment completed	**YES / NO**
I Statement/Outcomes discussed	**Partial Completed**
Funding arrangements identified	**YES / NO**
Client / family advised of cost of service and options re payment discussed – signposted to Service and Operations manager for action if needed	**YES / NO**
Recommendations **Case closed?**	**Details:** **YES / NO**