

Acquired Brain Injury Ireland Referral Form



WHEN COMPLETING THIS 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
 Nationality/Country of Origin: _____

Referred for:
 Residential
 Transitional
 Community Rehab
 Case Management
 Day Service
 Health Service Executive Area: _____

GP

Name: _____
 Address: _____

 Tel Number: _____
 Mobile Number: _____

NEXT OF KIN / MAIN CARER

Next of Kin:
 Name: _____
 Address: _____

 Tel No: _____ Mobile No: _____
 Relationship to person referred: _____

Main Carer / Contact Person (if different to above):
 Name: _____
 Address: _____

 Tel No: _____ Mobile No: _____
 Relationship to person referred: _____

SOCIAL INFORMATION

Family Support: Parent Children Siblings Spouse/Partner Other
Relationship: Single Married Co-habiting Separated Divorced Widow
Living Situation: Alone With Family With Partner Hospital Residential Other
Children: Number of Children over 18yrs ____ Number of Children under 18 yrs ____
Employed at Time of Injury: Yes No
Type and Duration of Employment: _____

FINANCIAL INFORMATION

PPS (RSI) No: _____
Medical Card
Medical Card No (if applicable): _____

Disability Allowance
 Long Term Illness Book
 Pension
 Other _____
Ward of Court

DETAILS OF ACQUIRED BRAIN INJURY (ABI):*USE ADDITIONAL PAGE IF REQUIRED*

Date of Injury: / /

Cause of Injury: _____

Circumstance of Injury: Home Work Sport Other: _____**Traumatic Brain Injury:**

Road Traffic Accident: Vehicle Driver
 Vehicle Passenger
 Bicycle
 Motorcycle
 Pedestrian

Assault: Gunshot
 Battery
 Physical Assault

Fall:

Other: _____

Non Traumatic Brain Injury:

Vascular Accident: Stroke
 Aneurysm
 Haematoma
 Haemorrhage
 Sub-arachnoid Haemorrhage
 Sub-dural Haemorrhage

Eating Disorder: Toxic or Metabolic Insult:

Overdose: Accidental
 Intentional

Infection: Meningitis
 Encephalitis
 Other

Tumour:

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

Cerebral Anoxia/
Hypoxia:

Other inflammation of the Brain: _____

PRIMARY DIFFICULTIES:*PLEASE CIRCLE ALL THAT APPLY*

Thinking Skills: Memory, Concentration, Planning, Organising, Decision Making, Orientation, Insight.
Communication: Language Expression, Language Comprehension, Social Skills, Relationships.
Behaviour: Impulsive, Disinhibited, Irritable, Aggressive, Passive.
Mood: Tearfulness/Depression, Mood Swings, Worry/Anxiety, Reduced Confidence, Suicidal.
Physical: Wheelchair User, Poor Mobility, Hemiparesis, Weakness, Poor Balance, Fatigue, Pain, Epilepsy, Diabetes.
Sensory: Problems With Eyesight, Hearing, Sensitivity to Touch, Sense of Smell, Sense of Taste.
Basic Care Needs: Incontinence, Personal Hygiene, Toileting, Self-Medication, Independence Skills, Eating And Drinking.

HISTORY OF THE ACQUIRED BRAIN INJURY*USE ADDITIONAL PAGE IF REQUIRED***Hospital Admissions & Dates**

Hospital Name: _____	Admission date: / /	Discharge date: / /
Hospital Name: _____	Admission date: / /	Discharge date: / /
Hospital Name: _____	Admission date: / /	Discharge date: / /
Hospital Name: _____	Admission date: / /	Discharge date: / /

Consultants attended

Name: _____	Hospital: _____
Name: _____	Hospital: _____
Name: _____	Hospital: _____
Name: _____	Hospital: _____

ASSESSMENTS CARRIED OUT:

USE ADDITIONAL PAGE IF REQUIRED

*If uncertain about names of professionals or dates, please write the location of the assessment***Psychological Assessments**Yes No

Name of Assessor: _____

Location: _____

Date: / /

Assessment Reports Enclosed Yes No **Occupational Therapy Assessments**Yes No

Name of Assessor: _____

Location: _____

Date: / /

Assessment Reports Enclosed Yes No **Speech & Language Assessments**Yes No

Name of Assessor: _____

Location: _____

Date: / /

Assessment Reports Enclosed Yes No **Physiotherapy Assessments**Yes No

Name of Assessor: _____

Location: _____

Date: / /

Assessment Reports Enclosed Yes No **Please Specify Other Assessments Carried Out:****Please Specify Any On-Going Therapy****Current Medication:****Reason For Referral / Other Referral Information:****RELEASE OF INFORMATION**

Please note that we cannot process referrals unless they are accompanied by written informed consent to the release of information and authorisation of discussion between care/service providers.

PLEASE SIGN THE ACCOMPANYING CONSENT FORMS

PLEASE PROVIDE THE FOLLOWING INFORMATION (IF RELEVANT) TO ASSIST US IN IDENTIFYING ANY ADDITIONAL SUPPORTS THAT MAY BE REQUIRED

MEDICAL INFORMATION

Previous History of Head Injury Yes No

Epilepsy Prior To Brain Injury Yes No

Previous Medical History / Illness / Hospitalisation:

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 Please Specify: _____

Name of Treatment Programme: _____

Dates of Treatment: ____ / ____ / ____ to ____ / ____ / ____

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

Name of Treatment Service _____ Date Started: ____ / ____ / ____

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:

HOUSING

Is the person registered on the Local Authority List? Yes No

If Yes, Housing Registration No. _____

REFERRAL DETAILS - THIS MUST BE FILLED IN

Date of Referral: ____ / ____ / ____

Name of person completing this form: _____

Relationship to person referred: _____

Agency where relevant? _____

Address: _____

Acquired Brain Injury Ireland is a CARF Accredited Organisation. (www.CARF.org)

PLEASE RETURN THIS FORM TO: