ACQUIRED
BRAIN INJURY
IRELAND

Referral Form

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

Acquired Brain Injury is an injury to the brain that has occurred after birth. This can occur as a result of a:
Fall, Assault, Accident, Infection, Stroke, Tumour, Concussion or a Road Traffic Accident.

To be eligible for referral to the service, the person being referred must meet the following criteria *(please tick)*

- ☐ Have a primary diagnosis of an Acquired Brain Injury
- ☐ Aged 18 – 65 years
- ☐ Medically stable
- ☐ Willing to engage in a Cognitive Rehabilitation Programme

*If you have answered **No** to any of the above, the person may not be suitable for the service. Please contact the service to discuss the referral before proceeding.*

Please Note: The service is not suitable for People with degenerative conditions, with progressive organic disorders or with Alcohol Related Brain Injury

Please provide the following documentation with the referral form

Proof of an Acquired Brain Injury *(tick relevant box below to indicate source of information)*

☐ Hospital Assessment ☐ Neurologist / Medical report ☐ CT / MRI Scan

Other *(please specify)*

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.....

☐ Completed consent forms (if not, why not?)

.....

.....

Has the person being referred history of substance use ☐ Yes ☐ No
If Yes, send details of treating physician / current support plan with referral

If current, has the person completed a voluntary period of abstinence of at least 3 months? ☐ Yes ☐ No

If previous, has the person completed a Rehabilitation Programme? ☐ Yes ☐ No

Has the person being referred a history of psychiatric illness ☐ Yes ☐ No
If Yes, send details of treating physician / current support plan with referral

To ensure that the referral is processed promptly, please ensure that all relevant documentation is provided, as incomplete referral forms will not be processed

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Personal Details

First Name:

Surname:

Maiden Name:

Address:

Eircode:

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:

Eircode:

Tel No:

Mobile No:

Next of Kin 1

Name:

Address:

Eircode:

Tel No:

Mobile No:

Relationship to person referred:

Next of Kin 2

Name:

Address:

Eircode:

Tel No:

Mobile No:

Relationship to person referred:

Main Carer / Contact Person (if different to Next of Kin):

Name:

Address:

Eircode:

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: ☐ No. of children over 18yrs ☐ No. of children under 18yrs

Employed at Time of Injury: ☐ Yes ☐ No

Type and Duration of Employment: ☐ Years ☐ Months

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

☐ Sporting Accident

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

Other:

Non Traumatic Brain Injury:

☐ Stroke
- ☐ Ischaemic Stroke
- ☐ Intracerebral haemorrhage
- ☐ Subarachnoid haemorrhage

☐ Infection
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Other

☐ Anoxia/Hypoxia (lack of oxygen)

☐ Eating Disorder

☐ Toxic or Metabolic Insult

☐ Overdose: Accidental

☐ Overdose: Intentional

☐ Tumour

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

Other neurological conditions

Specify:

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.

☐ 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: / /
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: / /
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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:

Eircode:

Email:

Mobile Number:

Please Return Completed Referral form to :

For Office Use Only

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