ACQUIRED
BRAIN INJURY
IRELAND

List of Referral Sources

If you wish to make a referral to Acquired Brain Injury Ireland to access services for yourself or a family member / loved one, please ask one of the following individuals or services to complete the referral form on your behalf:

- GP;
- Case Manager with Acquired Brain Injury Ireland or HSE;
- Allied Healthcare Professional (Occupational Therapist, Physiotherapist, Speech and Language Therapist, Social Worker etc);
- Hospital medical professional (e.g. Consultant);
- Community Disability Service Providers (e.g. Headway, RehabCare, Irish Wheelchair Association, Enable Ireland etc).
- Community Mental Health Team;
- Primary Care.

This list is not exhaustive.

If you are unsure about who to approach in order to make a referral, please contact Acquired Brain Injury Ireland to discuss on 01-280 4164.

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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)*

....

....

☐ 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

Referral Form

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

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:

Nominated Contact Person 1 (e.g. family/friend)

Name:

Address:

Eircode:

Tel No:

Mobile No:

Relationship to person referred:

Nominated Contact Person 2 (e.g. family/friend)

Name:

Address:

Eircode:

Tel No:

Mobile No:

Relationship to person referred:

Main Carer / Contact Person (If different to Nominated Contact):

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: / /
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:

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:

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

ACQUIRED BRAIN INJURY IRELAND

Release of Information – Referral to Acquired Brain Injury Ireland:
Where the Person Can Legally Sign for Themselves

Name of Person Referred: ....

Date of Birth: .... / .... / .... (dd/mm/yyyy)

Part A)

I hereby give consent to Acquired Brain Injury Ireland to obtain information on my clinical, educational and occupational history. I understand that this information may be used to assess the suitability of Acquired Brain Injury Ireland Services to my needs / to tailor services to my needs / in the provision of rehabilitation services. I understand that Acquired Brain Injury Ireland will hold my information on a secure electronic database and in a secured hard copy.

.... Date: .... / .... / .... (dd/mm/yyyy)

Signature of Person Referred

Part B)

I hereby give consent for Acquired Brain Injury Ireland to release reports and information on my rehabilitation and progress to my G.P. and other clinicians involved in my care.

.... Date: .... / .... / .... (dd/mm/yyyy)

Signature of Person Referred

I understand that I may revoke this consent at any time by writing to Acquired Brain Injury Ireland. If information has already been released based on my consent, my request to stop the consent will not apply to information already released.

In line with the Data Protection Act 2018, any information received by or disclosed by Acquired Brain Injury Ireland about individuals (including electronic information) will only be held with regards to the intended purpose i.e. to assess a referred person's needs in order to identify if and how Acquired Brain Injury Ireland can meet their needs. If the person referred is offered a service, the assessment information will remain on the individual's file. Anonymised information will be used by the organisation to monitor the demand for services and to monitor the effectiveness of the service. We may also use this to inform organisational development and business priorities and to publish anonymised service outcomes.

Date for consent review: .... (Office Use Only)

Release of Information – Referral to Acquired Brain Injury Ireland:
Where the Person Cannot Legally Sign for Themselves

Name of Person Referred: ....

Date of Birth: ..../........../.......... (dd/mm/yyyy)

Part A)

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.... Date: ..../........../.......... (dd/mm/yyyy)

Signature of Legally Appointed Person

Part B)

I hereby give consent for Acquired Brain Injury Ireland to release reports and information on my rehabilitation and progress to my G.P. and other clinicians involved in my care.

.... Date: ..../........../.......... (dd/mm/yyyy)

Signature of Legally Appointed Person

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Date for consent review: .... (Office Use Only)

ACQUIRED
BRAIN INJURY
IRELAND

Consent to Record/Release Nominated Person Contact Details:

Name of Person Referred: ....

Date of Birth: ..../........../.......... (dd/mm/yyyy)

If your contact details have been included as a Nominated Person, it is necessary for us to capture your consent to hold your information and to release your information only when relevant to the individual's rehabilitation. This is necessary to provide rehabilitation and to protect the vital interests of the person served.

We will not share your information with third parties for marketing purposes or promotions. For more information please see our Privacy Policy at https://www.abiireland.ie/privacystatement.

I understand that I may revoke this consent at any time by writing to Acquired Brain Injury Ireland. If information has already been released based on my consent, my request to stop the consent will not apply to information already released.

I hereby give consent to Acquired Brain Injury Ireland to process my personal data in accordance with the above.

....

Signature of Nominated Representative

Date: ..../........../.......... (dd/mm/yyyy)

....

Relationship to Person Referred

In line with the Data Protection Act 2018, any information (including electronic information) received by or disclosed by Acquired Brain Injury Ireland about individuals will only be held with regards to the intended purpose i.e. to assess a referred person's needs in order to identify if and how Acquired Brain Injury Ireland can meet their needs. If the person referred is offered a service, the assessment information will remain on the individual's file. Anonymised information will be used by the organisation to monitor the demand for services and to monitor the effectiveness of the service. We may also use this to inform organisational development and business priorities and to publish anonymised service outcomes.

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