HEADWAY BEDFORD – REFERRAL FORM

Bedford Health Village, Kimbolton Road, Bedford, MK40 2NT
Tel: 01234 310 310 **email:** mail@headwaybedford.org.uk

Headway House is a rehabilitation unit for people with non-degenerative acquired brain injury, their families and carers. Our aim is to engage people in activities which keep them focussed on regaining the ability to function purposefully in the community. We have a participative approach and provide physical, cognitive and social rehabilitation activities. On-site services include physiotherapy, speech therapy, occupational therapy, memory, cognitive classes, fatigue management, computer tuition and group work. Information, advice and guidance are available to clients, families and carers. We also provide visits to clients and families in their homes, encouraging participation by family and carers.

In order to provide the best possible service to your client, it would be helpful if you could attach any formal assessments or reports you have.

Title (Mr/Mrs/Miss/Ms) Other	
Full name	
D.O.B	
NHS number	
Marital status	
Present address	
Telephone number	
Mobile number	
Hospital admitted to	
Diagnosis	
Date of onset	
Relevant past medical history	
Pre-existing learning difficulties or mental health issues	

REASONS FOR REFERRAL

Brief description of presenting symptoms

Main problems and effect on client's life
What is the reason for this referral? What would you like Headway to focus on? **(EG: Rehabilitation, prevent social isolation, respite, maintenance of existing skills)**
Are there any known risks to visiting this client in their home? **Is the client at risk of wandering / absconding while at Headway?**
Client's first language (if not English)

Next of Kin name and telephone number	
GP name and telephone number	
Name of referrer and telephone number	
Job title and organisation of referrer	
Signature of referrer Date	
Where did you first hear about Headway?	

Please note:
In order to work more effectively with the client referred, we require as much information as possible. We do appreciate that you may not know the level of detail we are requesting, however if you do, please state.

PHYSIOLOGICAL FUNCTIONS (Hearing, toileting needs and mobility)

Hears clearly		Good sight unaided	
Partially deaf		Can see with glasses	
Totally deaf / uses hearing aids		Partially sighted / Blind	
Other: (specify)		Visual Neglect / Hemianopia	

Fully continent		Number of people required to assist toileting	
Occasional incontinence of urine / faecal		Specify adaptive equipment needs	
Stoma		Assistance emptying catheter bag	
Indwelling catheter/sheath		Assistance with hygiene after toileting	

Walks unaided		Able to manage stairs		Independent in wheelchair	
Walks with assistance		Able to weight bear		Other:	
Walks with aid (Specify)		Chair bound			

COGNITIVE FUNCTIONS (Communication, problems with cognitive functioning, mood and sleep)

Speaks clearly		Difficulty reading or writing?	
Comprehends but cannot speak		Word finding difficulties?	
No comprehension or speech		Alternative communication:	

Memory		Concentration / attention		Sensitivity to noise/ light	
Information processing		Poor insight		Motivation problems	
Planning and organising		Disorientation / confusion		Prompts to initiate/complete tasks	
Multi-tasking		Inattention / neglect		Fatigue	
Reasoning/problem solving		Disinhibited		Other: (specify)	

Tearful / depressed / worries / anxious		Withdrawn	
Irritable, easily frustrated, quick to anger.		**Any related risk factors: (please state)**	

Sleeps well		Disturbed sleep	
Difficulty getting to sleep		Other: (Specify)	

SELF CARE CAPACITY (Eating, drinking, safety and medication)

Drinks unaided		Eats unaided	
Needs some assistance (Specify)		Special dietary needs (Specify)	
Needs to be fed		PEG	
Swallowing difficulties		Social/religious requirements (specify)	
Allergies		Other:	

Can be left alone all or part of the day		Not safe to leave	
Suffers with dizziness		At risk of wandering/absconding	
Other: (Please state)			

No medication		Self medicates	
Needs medicines dispensed / administered		Needs supervision to ensure meds are taken	
Other: (Specify)		Use of alcohol or non-prescribed drugs	

Physical and cognitive testing

Berg balance		Rivermead		MOCA		Barthel		MRS		6 min walking test	