HEADWAY JERSEY REFERRAL FORM

Referral date			
Name of person being referred			
Date of birth			
What gender do you identify with?	**Male**	**Female**	**Other:**
Address			
Contact number			
Email			

Referred by (name)		
Relationship / role		
Contact number		
Email		
Consent (given by person being referred)	☐ Yes	☐ No

Name of main carer/ emergency contact	
Relationship	
Address	
Contact number	
Email	

Name of GP	
GP Practice name	
Address	
Contact number	
Email	

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What is the primary reason for this referral?

- ☐ Day centre
- ☐ Family & Carer Support
- ☐ Physical rehabilitation
- ☐ Cognitive rehabilitation
- ☐ Advocacy
- ☐ Communication Group

Other agencies involved (please provide name of contact):

- ☐ Brain Injury Service
- ☐ JET
- ☐ Community Stroke Team
- ☐ Housing
- ☐ Mental Health Services
- ☐ Community Therapists
- ☐ Health and Community Service (Social Worker)
- ☐ Speech & Language
- ☐ Stroke Association
- ☐ Other (please give details)

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DETAILS OF INJURY

Date of injury	
Diagnosis	
Name of hospital attended	
Duration of admission	
Dr/ Consultant/ Neurosurgeon	

Acquired Brain Injury:

- ☐ **Vascular e.g. Stroke haemorrhage** (please give details)
- ☐ **Viral e.g. meningitis** (please give details)
- ☐ **Tumour** (please give details)
- ☐ **Hypoxic / Anoxic** (please give details)
- ☐ **Encephalitis (**please give details)
- ☐ **Other** (please give details)

Traumatic Brain Injury:

- ☐ **Road traffic collision (RTC)** (please give details)
- ☐ **Assault** (please give details)
- ☐ **Fall** (please give details)
- ☐ **Other** eg. Post-Concussion Syndrome (please give details)

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Please mark any of the following areas of function the person is having difficult with as a consequence of their injury:

- ☐ **Epilepsy**
- ☐ **Movement/Mobility/Balance**
- ☐ **Vision**
- ☐ **Hearing**
- ☐ **Taste/Smell**
- ☐ **Speech and language**
- ☐ **Behaviour**
- ☐ **Memory**
- ☐ **Other (**please give details**)**
- ☐ **Attention/Concentration**
- ☐ **Self-awareness/Insight**
- ☐ **Problem solving**
- ☐ **Pain**
- ☐ **Transfers**
- ☐ **Fatigue**
- ☐ **Emotions**
- ☐ **Anxiety**

Medical condition:

Please give a brief description of any other significant medical condition:

- ☐ **Diabetes** (please give details)
- ☐ **Cancer** (please give details)
- ☐ **Heart disease** (please give details)
- ☐ **Allergies** (please give details)
- ☐ **Other** (please give details)

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Risks:

Please provide details of any risks – including risks related to home visits

☐ No Known risks

☐ Known risks – please give details

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DECLARATION AND CONSENT TO BE SIGNED BY THE PERSON BEING REFERRED

Headway Jersey is committed to protecting your personal data in line with the General Data Protection Regulations and in order for Headway Jersey to support individuals in relation to their current circumstances, we need permission to obtain, share and hold your personal data both internally between staff & volunteers and external third parties/agencies.

Please read the attached Privacy Notice which sets out:

What personal data Headway Jersey processes about you, the reason it processes that personal data, its legal basis for processing that personal data and how long it will process it for

- How we use your information
- Who Headway Jersey may share your personal data with
- Who to contact in the event that you have any queries relating to your personal data
- What rights you have in relation to your personal data, and how to exercise them

CONSENT

I hereby consent to Headway Jersey's permission to obtain, hold and share personal data in order to conduct its business and provide support whilst using its services.

I hereby consent to an authorised Headway Jersey employee to act on my behalf and liaise with the appropriate agencies in relation to my current circumstances.

Tick all that apply

☐ GP ☐ Therapy Personnel ☐ Health Community Services

☐ Hospital Staff ☐ Customer & Local Services ☐ Other (please specify)

Information I do not wish to share (please state): ____

Person/Agency I do not wish to share information with (please state) _________________________

HEADWAY JERSEY REFERRAL FORM

You have the right to withdraw you consent in writing at any time.

Signature of person being referred ____________________________________

Printed Name ____

Date: ____

HEADWAY JERSEY REFERRAL FORM

IMPORTANT

We cannot accept incomplete referrals. Please ensure that you have completed all sections including the consent to process and share information form.

REFERRAL CHECKLIST

- ☐ **Referral Form**
- ☐ **Evidence of brain injury e.g. GP / medical information**
- ☐ **Consent to Process and Share Information Form**

Please send the completed form to:

Headway Jersey Limited
The Community Centre
Le Coie
Springfield Road
St. Saviour
JE2 7DN

Tel number: 01534 505937
E-mail: headwayinjersey@gmail.com

Headway Jersey is committed to protecting all personal information collected and is transparent about why we do so and what we do with it.

For full details please see the Privacy Policy section on our website Privacy – Headway Jersey

To request specific information about our Data Protection procedure please use the following email headwayinjersey@gmail.com