**COMMUNITY BRAIN INJURY SERVICE REFERRAL FORM**

Please complete all sections of the referral form and send electronically to cbiservice@nhft.nhs.uk or cbiservice.nhft@nhs.net

Please ring 0300 027 2106 to confirm that the referral has been received.

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| **Name** | **Date of Birth** | **NHS Number** | **Date of referral** |
| **Patients address** **Is this the same address on discharge?** | **GP name, address and telephone number** |
| **Patients telephone number** | **Name, job title and telephone number of referrer** |
| **Patients email address** |
| **How will the worker gain access to the property?** *e.g. key safe number* | **Referring Hospital/Ward/Unit** |
| **Is an interpreter required?** | **Consultant** |
| **Are there any identified risks for workers/lone working at the property?** |
| **Date of brain injury** | **Initial GCS** | **Current GCS** | **Is the patient medically stable for discharge?** | **Planned discharge date** |
| **Discharge location** |
| **Brief details of the brain injury, scan results and medical intervention** |
| **Brief overview of the presenting problems whilst in hospital** *e.g. Physical, functional, behavioural, mood, cognitive impairments.* |
| **Does the patient have insight and awareness into their brain injury?** | Yes | No | **Does the patient present with challenging behaviour?** | Yes | No |
| **Relevant past medical *history*** *(please give details of any medical and mental health history that could affect rehab potential)* |
| **Identified rehabilitation goals on discharge** |
| **Current mobility and functional independence**  |
| **Brief details of any outcome measures used, scores attained and date when completed?** |
| **Has any equipment been issued to the patient for discharge?** *This would include splints and orthotics.* |
| **Have any referrals been made to other services?** *e.g. wheelchair services* |
| **Is there a care package in place for the patient on discharge?** **Who is the care provider?****Number of care hours in place:** |
| **Is the patient aware of their referral to the CBI service?** |
| **To be completed by the CBI Service** |
| Date referral received | Date referral reviewed | Referral accepted/declined – reason for decline |
| Priority - | Triage Date |
| CBI staff members name and designation that the referral was reviewed by |