**COMMUNITY BRAIN INJURY SERVICE REFERRAL FORM**

Please complete all sections of the referral form and send electronically to [cbiservice@nhft.nhs.uk](mailto:cbiservice@nhft.nhs.uk) or [cbiservice.nhft@nhs.net](mailto: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 | | | | | | | | | |