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**Referral Criteria for Derby Head Injury Team**

The Head Injury service provides highly specialised physical and cognitive assessment and treatment in an Outpatient setting. The team consists of a Team Leader, Case Manager, Occupational Therapy, Physiotherapy, Speech and Language Therapy, medical input from a Consultant in Rehabilitation Medicine and access to Clinical Neuropsychology.

The team does not provide a crisis management service.

The team will accept referrals from GP’s, Consultants and Allied Health Professionals.

Individuals who are referred to Derby Head Injury service should meet the following criteria:

* Sustained a traumatic brain injury within the last 3 years (resulting from a car accident, fall or assault for example and does not include an acquired brain injury due to SAH, stroke, or other neurological condition).
* Clinically fit and medically stable to undertake treatment in an outpatient setting.
* To be able to tolerate travel to/from appointments at Florence Nightingale Community Hospital.
* Aged 16 or over.
* Registered with a Derby City, Amber Valley, Erewash, South Derbyshire and East Staffordshire GP.
* Must have active rehabilitation goals clearly identified on the referral and demonstrate motivation to participate in rehabilitation.
* If individuals have multi-pathology, the objectives of the referral should be primarily associated with the TBI. Any secondary problems should not be so significant that they exclude them from benefiting from TBI rehabilitation.
* Require a highly specialist brain/head injury rehabilitation service that explores all areas of difficulty including emotional, adjustment to disability, vocational, physical, functional, vestibular, communication, cognition and behaviour (for example, poor memory or concentration that impede their quality of life and/or prevent them from returning to work or reduce their ability to live independently).
* Referrals are also accepted for diagnostic purposes: i.e. to ascertain whether potential changes in cognitive functioning may be due to the TBI or other medical factors.
* Patients previously known to the service can be re-referred on an assessment and advice basis of up to three sessions.

**Exclusion criteria**

* A primary mental health problem or severe behavioural difficulties that cannot be managed in the community without specialist support may not be accepted to this service.
* Alcohol or drug dependency and unable to comply with treatment plan.
* Previous regular failure to attend assessment/treatment sessions.
* Rehabilitation needs already been definitively completed by the provision of private sector.
* Background of dementia impedes their ability to effectively learn or carry over rehabilitation strategies.

**To submit a referral using the form below or to discuss any queries please contact the team:** [**dhft.specialistrehabilitation@nhs.net**](mailto:dhft.specialistrehabilitation@nhs.net)

**SPECIALIST REHABILITATION SERVICES**

**OUTPATIENT HEAD INJURY TEAM REFERRAL FORM**

* Please provide as much clinical information as possible to avoid us having to contact you for further details
* Please ensure patient details are up to date on the National Spine to ensure we are able to contact the patient with their appointment details
* **Please note referrals will be returned if rehabilitation goals are not clearly stated or form not fully complete.**

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| **PATIENT DETAILS** | | | |
| NHS / Hosp. No |  | Correspondence address / patient’s current location / contact number |  |
| Title |  |
| First Name(s) |  |
| Surname |  |
| D.O.B |  |
| Gender |  |
| GP Name & Address |  | Specific communication needs - *(visual/hearing impaired, interpreter – language?)* |  |
| Are there any identified safeguarding issues? | | No Yes  If yes, please provide information in clinical info below or contact team to discuss. | |
| Is patient aware and consents to referral? | | No Yes | |
| Are there any mobility, transfer or travel needs that will affect clinic attendance? | |  | |
| Expected date of discharge from hospital (if applicable)? | |  | |

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| **ALTERNATIVE CONTACT DETAILS** | | | |
| First Name(s) |  | Address  *(incl. Postcode)* |  |
| Surname |  |
| Relationship |  |
| Contact number(s) / details |  | | |

Please include any recent reports/relevant information

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| **REFERRAL DETAILS** | | | |
| Cause of TBI |  | Date of Injury |  |
| Loss of consciousness | Yes No  Length of time | Initial GCS |  |
| Length of post traumatic amnesia if present |  | | |
| Any other Injuries sustained at time of accident | Yes No Not known | Seizures | Yes No |
| CT/MRI results |  | | |
| Current treatment & medication |  | | |

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| Past medical history incl. mental health history |  |
| Relevant clinical information, and any other factors to consider | *e.g. transfers and mobility, falls, tone management, balance, pain, psychological issues, cognition (incl. capacity), fatigue, gait, medication advice, dizziness, word finding/language difficulties.* |
| **Current clinical issues and specific rehabilitation goals** |  |
| Relevant professional input required  *(please tick all that apply)* | Occupational Therapy  Vestibular assessment  Speech and Language Therapy  Case Management  Physiotherapy  Rehab Medicine Consultant  Neuropsychology |

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| **Social History** | |
| If known, what type of accommodation is the patient currently residing in and are there any notable features  *e.g. flat, bungalow, house* | |
| Does the patient live alone | Yes No Not Known |
| Does the patient have any caring responsibilities | Yes No Not Known |
| Level of functional ability prior to head injury:  What formal and informal support systems are in place? | |
| Vocational information i.e. employment status/education | |

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| **OTHER PROFESSIONALS**  *Please list any other professionals involved in this patients care (include healthcare, social care and any other agencies)* | | |
| **Name** | **Role** | **Contact details** |
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| **OTHER RELEVANT INFORMATION** |
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| **REFERRER DETAILS** | | | |
| Date of referral |  | Address  *(incl. Postcode)* |  |
| Name |  |
| Designation |  |
| Contact number |  | Contact e-mail |  |
| **Please attach and submit with the eRS referral or e-mail to** [**dhft.specialistrehabilitation@nhs.net**](mailto:dhft.specialistrehabilitation@nhs.net) | | | |