Referral Form

Guidelines for referrals

Please complete all sections of the referral form to avoid any delay. We would be grateful for as much medical and social information as possible, including any discharge summary, if available.

### We will not process referrals from acute settings without the discharge location and date.

Livability Icanho offers specialist comprehensive inter-disciplinary assessment, identification of problems/goals and customised rehabilitation programmes, with regular reviews.

The clinical team is comprised of Neuro-specialist Occupational Therapists (including vocational rehabilitation), Physiotherapists, Speech and Language Therapists, Social Worker, Clinical Psychologists, a consultant in rehabilitation medicine, and Rehabilitation Assistants. The rehabilitation programmes may include attendance at Livability Icanho, work within individuals’ homes or in the local community.

Telephone enquiries are welcome if you are uncertain about a referral, or wish to discuss specific issues/needs. If individuals are not eligible for statutory funding, Livability Icanho can also offer private rehabilitation services.

For all enquiries, please telephone **(01449) 774 161**

## How to refer

Complete the referral form and send to either of the following:

Post: Clinical Lead, Livability Icanho, Chilton Way, Stowmarket, Suffolk, IP14 1SZ

Fax: 01449 776100 Email: [enquiries.icanho@livability.org.uk](mailto:enquiries.icanho@livability.org.uk)

**(Please encypt email)**

Statutory referral criteria

* Diagnosed with an acquired non-progressive brain injury, including trauma, stroke, haemorrhage, infection or tumour. If individuals have multi-pathology, the brain injury should be their primary diagnosis. Any secondary problems should not be so significant that they exclude them from benefitting from brain injury rehabilitation.
* Require a **highly specialist** brain injury rehabilitation service that explores all areas of difficulty including social, family, emotional, adjustment to disability, vocational, physical, functional, communication, cognition and behaviour.
* Those with family or social issues impacting on recovery/rehabilitation that require a specialist acquired brain injury social worker input.
* Medically stable and well enough to be able to benefit from community rehabilitation/Icanho service.
* Have the potential to benefit from, and the willingness to participate in, the rehabilitation process.
* Aged 18 or over.
* Registered with a Suffolk GP.
* Time frame for acceptance of referral is **up to 1 year** **from** the point of discharge from acute care.
* If the person is in residential care, or is aged 16-17, or had their injury more than 12 months ago, **exceptional** referrals may be considered for Icanho rehabilitation, via the relevant CCG Individual Funding Request panel. **The referrer is advised to make this application through the CCG web site.**

Those clients who have a primary mental health problem, or severe behavioural difficulties that cannot be managed in the community with specialist support, will not be accepted to this service.

Data consent form

**Address Label**

**Name: ………………………………………….**

**Client No. …………………………………….**

|  |  |  |
| --- | --- | --- |
| Yes | No | Question |
|  |  | 1. I give consent for face to face (in the centre or my home) and/or remote therapy sessions |
|  |  | 1. I give consent for appointments to be e-mailed to me |
|  |  | 1. I give consent for all information to be emailed to me, including clinical meetings/reports/letters |
|  |  | 1. I give consent for Icanho to request and/or release medical information about me with any relevant medical/social care professional. |
|  |  | 1. I give consent for Icanho to retain a clinical file about me to ensure rehabilitation interventions are recorded. |
|  |  | 1. I give consent for Icanho to use data about me for service development/audit and outcome reporting to the CCG/NHS/Social Care. |
|  |  | 1. I give consent for Icanho to share relevant information with the following family/friends/employer/solicitors (please list below) |

|  |  |  |
| --- | --- | --- |
| Family Member/Friend | Date | Signature |
|  |  |  |
|  |  |  |
| Employer/Line Manager/Solicitor |  |  |
|  |  |  |
|  |  |  |
| Lasting Power of Attorney |  |  |
|  |  |  |

**Signature…………………………….. Date…………………………………………**

Client unable to consent/information sharing due to reduced mental capacity and therefore decision made in best interests

**Name…………………………………. (Icanho team rep) Date:………………………**

**Signature……………………………..** **Reassessment date:…………………………….**

Copy provided to client

*Please note that this request is made under the General Data protection Regulation 2016/679 and Data Protection Act 2018. Details are available in the Client Information leaflet provided at assessment and on request. This consent applies throughout your rehabilitation at Livability Icanho, but you can withdraw consent at any time by advising any team member.*

Livability Icanho referral form

**NHS No:**

Personal Details:

|  |  |  |
| --- | --- | --- |
| **Name** |  | |
| **Address** |  | |
| **E-mail** |  | |
| **Tel No** | **Mobile: Landline:** | |
| **Date of Birth** |  | **Male / Female** (please circle) |
| **Ethnic Group** |  | |
| **Religion/faith** |  | |
| **Language(s)** | **1st:** | **2nd:** |

**If not at above address, please give current location:**

|  |  |  |
| --- | --- | --- |
| **Address**  (including  Post Code) |  | **If in acute setting:**  **Discharge location (address/postcode):**  **Discharge date:** |
| **Tel No.** |  |  |

**Next of kin details:**

|  |  |
| --- | --- |
| **Name** |  |
| **Address**  (including  Post Code) |  |
| **Tel No.** |  |
| **Relationship** |  |

**Carer details (if different to Next of Kin):**

|  |  |
| --- | --- |
| **Name** |  |
| **Address**  (including  Post Code) |  |
| **Tel No.** |  |

**GP details:**

|  |  |
| --- | --- |
| **Name** |  |
| **Address** (including  Post Code)  **Tel No.** |  |

Medical details:

|  |  |  |
| --- | --- | --- |
| **Principal diagnosis & site of damage** (if known) |  | |
| **Icanho classification** *(leave blank)* |  | |
| **Date of onset** |  | |
| **Scan results** | **MRI**  **CT**  **Other** | |
| **Glasgow Coma Score (GCS)** | **At incident** | **On admission to A&E** |
| **Post-traumatic Amnesia** |  | |
| **Consultant(s) involved** |  | |
| **Neurosurgery** (details & date  if applicable) |  | |
| **On going medical issues** |  | |
| **Past medical history** |  | |
| **Current medication** (name drugs & dosage) |  | |

Reason for referral:

\*Please continue on a separate sheet if necessary **and attach any relevant scans, test results and reports as necessary.**

Does the person referred experience problems in any of the following areas?

|  |  |  |
| --- | --- | --- |
|  | **✓** | Please give details |
| **Physical/mobility** |  |  |
| **Functional** |  |  |
| **Communication** |  |  |
| **Cognitive** |  |  |
| **Behavioural/Emotional** |  |  |
| **Social Interaction** |  |  |
|  |

Social and work situation:

# e.g. type of property, lives alone, family circumstances, work situation)

## Other agencies involved or referred to a discharge: (include contact name and telephone no.)

# Is the individual aware of the referral?

# Yes No

Referrer information:

|  |  |
| --- | --- |
| **Name:** |  |
| **Discipline/relationship:** |  |
| **Address:** (including  Post Code) |  |
| **Tel No:** |  |
| **Signed:** |  |
| **Date:** |  |

Once completed, please return this form by encrypted email to [enquiries.icanho@livability.org.uk](mailto:enquiries.icanho@livability.org.uk) or by post to the Clinical Lead, Livability Icanho, Chilton Way, Stowmarket, Suffolk, IP14 1SZ