**ASSESSMENT REQUEST FORM**

Completion of this form does not constitute a formal application, but is part of the data gathering required for assessment purposes.

All information is held in the strictest confidence. Be assured that when you write, call or e-mail, we do not share, sell, trade or otherwise disclose any information at any time.

**Please complete this form and return via: Post:** TRU Assessment Services

**any of the following methods:** Margaret House, 342 Haydock Lane, Haydock, St Helens, Merseyside, WA11 9UY

**E-mail:** darrengibson@trurehab.com **Fax:** 01942 707030

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| **Service Required** |
| **[ ]  Neuro-Behavioural Residential Placement** | **[ ]  Long Term Living Residential Placement** |
| **[ ]  Community Re-entry Residential Placement** | **[ ]  Mental Health Service** |
| **[ ]  Community Outreach** | **[ ]  Substance Misuse Detoxification Programme** |
| **[ ]  Day placement Services** |  |

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| **Referral Source** |
| **Name:** | **Title:** |
| **Organisation:** | **Date of referral:** |
| **Address:** |
| **Telephone:** | **E-Mail:** |
| **Fax:** |  |

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| **Individual to be assessed** |
| **Surname:** | **Forename:** |
| **Date of birth:** | **Telephone:** |
| **Reason for referral:** |  |
| **Current address/placement:** |
| **Responsible Clinician (RC):** | **Care Co-ordinator / Case Manager:** |
| **Occupation:** | **Marital status:** |
| **Legal status (informal / detained):** | **Ethnic group:** |
| **Religion:** |  |
| **NHS Number:** | **National Insurance Number:**  |

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| **Client History** |
| **Cause and Nature of Brain Injury:** |
| **Any other relevant information:** |
| **Please also supply copies of background / medical reports if available** |

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| **Next of Kin** |
| **Name:** | **Affiliation:** |
| **Address:** |
| **Telephone:** | **E-Mail:** |

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| **Nearest Relative** **(for patients being referred under Section of the MHA)** |
| **Name:** | **Affiliation:** |
| **Address:** |
| **Telephone:** | **E-Mail:** |

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| **Funding Source** |
| **Name:** | **Title:** |
| **Name of organisation:** |  |
| **Address:** |
| **Telephone:** | **E-Mail:** |
| **Fax:** |  |

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| **GP details** |
| **Name:** |  |
| **Address:** |
| **Telephone:** | **E-Mail:** |
| **Fax:** |  |

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| **Are the following people aware of this referral?** |
| **Person referred** | **YES / NO** | **Medical Consultant: e.g. GP** | **YES / NO** |
| **Family** | **YES / NO** | **Funding Authority**  | **YES / NO** |

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| **Would you like a tour of TRU?** |
| **[ ]  Yes – To take place on date of assessment** |
| **[ ]  Yes – To take place prior to assessment** |
| **[ ]  No** |

**On receipt of the completed referral we will endeavour to have an admission assessment arranged with 14 days, or as soon as is mutually convenient.**

**Thank you.**