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: any of the following methods:

Post: TRU Assessment Services
Margaret House, 342 Haydock Lane, Haydock, St Helens, Merseyside, WA11 9UY

E-mail: darrengibson@trurehab.com

Fax: 01942 707030

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**	

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

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:	

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

TRU (Transitional Rehabilitation Unit) LTD
Margaret House, 342 Haydock Lane,
Haydock, St Helens, Merseyside, WA11 9UY

Tel: 01942 707000 Email: enquiries@trurehab.com
Fax: 01942 707030 www.trurehab.com
Registered in England and Wales Company Reg. No. 2708234

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

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

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

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

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**

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 completed referral we will endeavour to have admission assessment arranged with 14 days, or as soon as is mutually convenient.
Thank you.