Alcohol Related Brain Injuries
Case Coordination Service
Alcohol Forum Office
Unit B9
Enterprise Fund Business Park
Ballyraine
Letterkenny
Donegal
Tel- (074) 91 25596
Fax – (074) 91 25616

Alcohol-Related Brain Injury Referral Form

PATIENT DETAILS

Name	Address	Phone Number (Including Mobile)
Next Of Kin	Address	Phone Number (Including Mobile)

Date of Birth: ___/___/____ Age:_____ Language Spoken :_____
PCN:_____ PPS:_____ Medical Card No:_____

REFERRAL AGENCY

Referring person and position:_____

Practice/Organisation:_____

Address:_____

Telephone:_____ Mobile:_____ Fax:_____

Email:_____

Signature_____ Date of Referral: _____

SERVICE HISTORY

Has the patient previously had any of the following? If YES, provide details and attach any relevant reports/documentation:

□ **Psychological/Psychiatric/Mental Health Assessment**
□ **Intellectual Disability Assessment**
□ **Neuropsychological/Cognitive Assessment**
□ **Social Services Input**
□ **Occupational Therapy Assessment**
□ **Alcohol or Substance Detoxification/Rehabilitation or Addiction Services input**

MEDICAL INFORMATION

Please ask medical physician or general practitioner to complete ARBI Indicator & Risk Factors Tool to accompany this form

G.P Name:_____ **Practice:**_____

G.P Phone Number:_____

Current medications: _____

History of Head Injury: Yes☐ No☐
Please specify**:**
_____

RISK

Are any of the following relevant to the patient?

History of Self-Harm/Suicide Attempts ☐…….

Living with children and/or vulnerable adults ☐…….

Forensic History (aggression, violence etc.) ☐…….

Risk to Lone Workers ☐……

Living Alone ☐……

Any other relevant details:
_____
_____
_____

REQUESTED INTERVETION

Screening and Early Intervention ☐ Case Coordination ☐

CONSENT FOR REFERRAL

Referrals must have consent from the individual being referred. Please tick the boxes to confirm that consent for referral and consent for information sharing has been given.

Has the client consented to this referral? Yes ☐ No☐ Verbal ☐ Written ☐

Has the client consented to sharing of information? Yes☐ No☐ Verbal☐ Written☐

Client Signature:_____ Date:_____

Please be aware that there is a waiting list in operation for this service. It is advised that the person continue to be monitored and supported while this application is being processed and whilst the client is on the waiting list.

ARBI – INDICATORS & RISK FACTORS TOOL

Patient:
D/O/B:

Has the named patient presented with any of the following symptoms on this (or previous) admission?

Significant Alcohol Use		
Multiple alcohol-related hospital admissions or delayed discharges	Yes ☐	Please specify
Multiple detoxifications (assisted or unassisted)	Yes ☐	Please specify
Alcohol related hepatic, pancreatic, gastrointestinal, cardiovascular or renal disease or other end organ damage	Yes ☐	Please specify
Cognition: There is evidence of the presence of deficits in neurocognitive function		
Performance on a cognitive screening tool indicating cognitive impairment	Yes ☐	Please specify
Behavioural observations on medical ward indicating the presence of cognitive impairment	Yes ☐	Please specify
Reports or observations from a significant other of a notable decline in cognitive functioning	Yes ☐	Please specify
Doubts about capacity or ability to make reasonable decisions	Yes ☐	Please specify
Neuroimaging evidence of alcohol-related atrophy not due to traumatic causes OR a congenital, developmental, OR degenerative disorder OR from a progressive disease		
Cerebellar atrophy	Yes ☐	Please specify
Atrophy or gliosis of frontal lobe	Yes ☐	Please specify
Generalised atrophy	Yes ☐	Please specify
Ventricular or sulcal dilation	Yes ☐	Please specify
Neuro-observations		
Ataxic Gait (or other cerebellar sign)	Yes ☐	Please specify
Oculomotor dysfunction (nystagmus, bilateral lateral rectus palsy or conjugate gaze palsy)	Yes ☐	Please specify
Peripheral Neuropathy	Yes ☐	Please specify
Malnutrition		
Bloods (MCV/Vitamin mineral screen etc. /reduced BMI	Yes ☐	Please specify
Functional Limitations		
Difficulties with mobility and/or initiation/completion of ADL's resulting in concerns for safety	Yes ☐	Please specify

I can confirm that on the basis of previous or current admission that the named client is suspected of an ARBI and requires continued rehabilitation in a high support environment

Physician Signature:

.....

Date: .....