Queensland Government

Princess Alexandra
Metro South Health

SKILLS TO ENABLE PEOPLE & COMMUNITIES SKILLS PROGRAM

PARTICIPANT REFERRAL FORM

F1

Date:____________________

Local STEPS Group Location:

This form has been designed to be used by persons with a brain injury, service providers, friends, relatives, and carers to enrol themselves or someone else in a STEPS program.

PLEASE COMPLETE A SEPARATE FORM FOR EACH PERSON ATTENDING

1. PERSONAL DETAILS

Surname: ____________________ Given Name: __________________ Date of Birth*: ________________

Address: ____

Suburb: ______________________ Postcode: _____________________ Gender: ☐ Male ☐ Female

Phone: Home _________________ Business______________________ Mobile______________________

Email address: ____

**Please note: If you are under 18 years of age and want to participate in the STEPS group, you will need to be accompanied to all groupwork sessions by a guardian or an adult known to you.*

Person who should be contacted in the event of an emergency

Name: ______________________ Relationship: __________________ Phone number_________________

Culture:

☐ Aboriginal & TSI Origin ☐ Aboriginal not TSI Origin ☐ Torres Strait Islander
☐ Asian ☐ Caucasian ☐ South Sea Islander
☐ Other (please describe)____

Language:_ ____ Need Interpreter: ☐ Yes ☐No

2. REASON FOR ATTENDING (please tick all relevant):

☐ Carer (unpaid) ☐ A Spouse/ significant other ☐ Friend

☐ Paid support worker or carer ☐ Other family member (please describe)_______________________

☐ Health professional (please describe)____

☐ Member of local community (please describe) ____

☐ Other (please describe)____

☐ **Person with brain injury or stroke** Date of Injury:__________________

- ☐ Traumatic brain injury-motor vehicle accident
- ☐ Traumatic brain injury- fall
- ☐ Traumatic brain injury- assault
- ☐ Lack of oxygen to brain, e.g. heart attack suicide attempt, drug overdose, asthma attack
- ☐ Other ____
- ☐ Stroke
- ☐ Tumour
- ☐ Infection

Additional Diagnosis/Medical History: ____

3. ADDITIONAL INFORMATION (please tick all that apply and describe):

- ☐ Special dietary requirements____
- ☐ Epileptic seizure activity____
- ☐ Risk of aggressive or inappropriate behaviour____________________________
- ☐ Communication / language problems____
- ☐ Cognitive problems____
- ☐ Vision problems____
- ☐ Hearing problems____
- ☐ Physical restrictions____
- ☐ Wheelchair use ○ Manual ○ Electric ○ Scooter
- ☐ Other (please describe):____

Would the person attending the STEPS Skills Program like to bring a companion/spouse/friend/family member/neighbour to this program?

☐ Yes ☐ No ☐ Don't know

If **Yes**, who? Name: ________________________Relationship: ______________________________

Are you using this form to enrol yourself in the STEPS Skills Program?

☐ **Yes** If yes, you have completed this form, please send it to the address below.

☐ **No** If no, please provide some details about yourself below

4. DETAILS OF REFERRING PERSON:

Your Name: ____

Phone: ______________________Fax:___________________Email: ______________________

Postal address: ____

Relationship to the person being referred:______________________________________

If you are a service provider/agency, please provide your organisation and position: ________________

____

Send Form to:

Areti Kennedy, Program Manager, Skills To Enable People and CommunitieS (STEPS)
Acquired Brain Injury Outreach Service,
Post: PO Box 6053, Buranda Q 4102 Fax: (07) 3406 2399
Email: STEPS@health.qld.gov.au
Ph: (07) 3406 2311, outside Brisbane: 1300 727 403 (local call cost only)

OR Your Local Contact:

Name:________________________________Position:_____________________________________

Address:____

Ph:________________________Fax:__________________________Email:____________________________

OFFICE USE ONLY

Eligibility Screening: Is Eligible? ☐ **Yes** ☐ **No** Date______________________
Reason Ineligible: Action Taken:

☐ D/b ☐ Leader Checklist ☐ Participant List