HEADWAY
Brain Injury Services & Support

Headway Carers' & Family Support Group Intake Form

Name: ____

Address: ____

____

Date of birth: ______ / ______ / _______ Gender: M ☐ F ☐

Nationality_________________________________

Contact mobile-phone: _______________________

Would you like text reminders for up-coming support meetings? Yes ☐ No ☐

E-mail Address: _____________________________

Name of person we may contact in case of an emergency: _______________________

Your relationship to them (partner, sibling, friend etc.): _________________________

Emergency person's contact telephone number: _______________________________

Your GP's Name: __________________________________

GP contact number: ______________________________

Medical Conditions we should be aware of:

____

Medications:____

DETAILS OF FAMILY MEMBER'S ACQUIRED BRAIN INJURY (ABI):

Name of family member:____

Date & Nature of ABI:____

Your relationship to the person with ABI (parent, sibling etc.) ___________________________________

Is your family member currently accessing Headway Services? _____________________________

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From time to time Headway may wish to contact you to inform you of events and fundraising opportunities. Headway will not share this information with any other body or institution. Are you willing to be contacted in this way? Yes ☐ No ☐

If yes, please contact me using the following methods only : (Please tick all that apply)

By Post ☐ **By email** ☐ **By Phone Call** ☐ **By Text Message** ☐