



**Quest Brain Injury Services**

Part of National Learning Network

**APPLICATION FORM**  
**for**  
**Mayo and Roscommon**

**Programme Name: Quest Brain Injury Service 2021**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

## DATA PROTECTION STATEMENT – Individuals OVER 18 years of age

Name: \_\_\_\_\_

In compliance with the Data Protection Act 2018, The National Learning Network will keep personal information supplied to it only for lawful and specified purposes.

The National Learning Network will use your personal data for the purposes of processing your application, performing its obligations to you and to the funding authority in relation to providing training and related services and for general administration. Data will not be used or disclosed for any reason not compatible with these purposes.

Personal data relating to you will be processed in compliance with the Acts and will be stored in a secure, confidential and appropriate manner. The data will be stored only while it is relevant and will not be disclosed to a third party except with your consent or as required by law.

The Centre Manager/Co-Ordinator must make sure that each student/learner receives a copy of this document. When the signed document is returned, it must be securely stored in a locked cabinet and produced immediately if required.

### Personal Data

The National Learning Network is a Data Controller under the Data Protection Act 2018. The personal data that you supply to us is part of the registration process and is backed up by the Personal Data Processing Agreement. We rely on you to provide us with accurate information and to inform us of any change in the information provided. Should you wish to update or access your personal data, you should write to the Data Protection Office and request a Data Subject Access Request Form.

I understand my rights under Data Protection Legislation, as outlined on this form

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Personal Details

Name: \_\_\_\_\_ PPSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Eircode: \_\_\_\_\_ Phone/Mobile: \_\_\_\_\_  
email: \_\_\_\_\_

### Emergency Contact(s)

Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## Marital Status

Single  Married  Separated  Divorced  Widowed

If you have children or other dependents, please give details:

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## Current Situation

Please tell us about yourself, living alone with family etc.

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## Health

- Date of Brain Injury: \_\_\_\_\_
- Was there a loss of consciousness? Yes  No
- What was the nature of the brain injury?

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I consent to my Family Member/Significant Other being involved in my Rehabilitative Programme

Name: \_\_\_\_\_ Yes  No



Please give brief details of any other disability or health difficulty you may have:

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Please describe how this affects you:

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Please list any supports you think you may need (wheelchair access, interpreter, adaptive equipment, assistance with evacuation etc.)

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Please list any medication you are taking and give details of any side effects:

Medication	Side Effects

Do you self-administer medication? Yes  No

Do you require support to administer medication? Yes  No

Do you have any allergies? Yes  No

If Yes – give details

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Please complete the following, in case of accident or illness

Name of GP: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone No: \_\_\_\_\_



Please list any other professionals you are involved with:

(Consultant, Occupational Therapist, Social Worker, Community Health Nurse, Key Worker, etc)

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone No: \_\_\_\_\_

Phone No: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Referral Agent: (e.g. family member, GP, Psychologist)

Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship \_\_\_\_\_

\_\_\_\_\_

to Applicant: \_\_\_\_\_

Phone/Mobile: \_\_\_\_\_

email: \_\_\_\_\_

### Social Welfare Benefits

Are you receiving any of the following benefits?

Disability Allowance (DA)	<input type="checkbox"/>	Blind Persons Allowance	<input type="checkbox"/>
Invalidity Pension (IP)	<input type="checkbox"/>	Jobseeker's Allowance (JA)	<input type="checkbox"/>
Jobseeker's Benefit (JB)	<input type="checkbox"/>	One Parent Family Benefit	<input type="checkbox"/>
Other : Please give details		None	<input type="checkbox"/>

Are you registered with SOLAS? Yes  No

Do you have a Travel Pass? Yes  No

### Additional Information

#### Specialist Reports

What reports are available? Please provide copies if possible

General Medical	<input type="checkbox"/>	Community Care Assessment	<input type="checkbox"/>	Physiotherapy	<input type="checkbox"/>
Neurosurgical	<input type="checkbox"/>	Neuropsychological	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>
Neurology	<input type="checkbox"/>	Employment Service	<input type="checkbox"/>	National Rehabilitation Hospital	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	Other Residential Service	<input type="checkbox"/>

In order to assist us in providing a Service that is able to match your needs, it may be necessary for us to contact various people external to this organisation to request information relevant to your current situation. We will only do this if it is deemed necessary, appropriate and applicable, in accordance with the Data Protection Act 2018.

I give my consent to Quest ABI Service to communicate with external bodies in support of my application.

Yes  No

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please return this completed form to:**

***The Manager  
QUEST Brain Injury Services  
9A Liosbán Business Park  
Tuam Road  
Galway***



# Mayo/Roscommon Outreach ABI SERVICES

## STEP BY STEP APPLICATION PROCESS

