



***GABI services are open to individuals with an ABI aged 18 – 65 years of age.***

**What services do you wish to apply for?**

|  |  |
| --- | --- |
| **Service Model** | **Please tick** |
| **ABI Rehabilitation**  *This is a Community based service delivered jointly by RehabCare and Quest. This service provides individuals with flexible, specialist support and rehabilitation, tailored to each person's own needs and goals e.g. Brain Injury management and awareness, Personal & behavioural development, Life Skills management.* | ❑ |
| **Logan House**  *This is a specialist ABI supported residential service managed by RehabCare. Individuals applying for this service require specific residential supports in the management of their ABI.* | ❑ |

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# **DATA PROTECTION STATEMENT**

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

In compliance with the Data Protection Act, The Rehab Group will keep personal information supplied to it only for lawful and specified purposes.   
  
the Rehab Group 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 DPA 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 Rehab Group 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Eircode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ 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:

|  |
| --- |
|  |
|  |

# **Current Situation**

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

|  |
| --- |
|  |
|  |

# **Health**

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

|  |
| --- |
|  |
|  |

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:

|  |
| --- |
|  |
|  |
|  |

Please describe how this affects you:

|  |
| --- |
|  |
|  |
|  |

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

|  |
| --- |
|  |
|  |
|  |

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 |
|  |
|  |

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) ❑ | Blind Persons Allowance (BPA) ❑ |
| Invalidity Pension (IP) ❑ | Jobseeker’s Allowance (JA) ❑ |
| Jobseeker’s Benefit (JB) ❑ | One Parent Family Benefit ❑ |
| Other: Please give details ❑ | None ❑ |

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 ❑ | Community Care Assessment ❑ | Physiotherapy ❑ |
| Neurosurgical ❑ | Neuropsychological ❑ | Speech Therapy ❑ |
| Neurology ❑ | Employment Service ❑ | National Rehabilitation Hospital ❑ |
| Psychiatric ❑ | Occupational Therapy ❑ | Other Residential Service ❑ |

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 Disability Services Department  
c/o Galway Services ABI Clearing House  
Merlin Park Hospital  
Galway***

|  |  |
| --- | --- |
| **Office Use** | |
| **MDT Assessment** |  |
| **Quest** |  |
| **RehabCare** |  |
| **Joint** |  |
| **Outreach Support Hours** |  |
| **Residential** |  |

**GALWAY ABI SERVICES** **STEP BY STEP APPLICATION PROCESS**

Week

1

**Application**

Application form received by Galway Acquired Brain Injury Services Clearing House (Quest Brain Injury Services & RehabCare ABI Team) with clients consent to share information.

Reports will be requested from GP and other relevant health professionals.

Week

2

**Service orientation**

Applicant is contacted by a member of ***GABI*** prior to screening. Information regarding the application process, Brain Injury and other related supports will be provided.

Week

6

**Meeting**

Joint meeting with applicant by Quest Brain Injury Services and RehabCare ABI Team to determine if applicant is suitable for the services. If suitable. The service model may include inputs from one or both service providers. (Quest Brain Injury Services & RehabCare ABI Team)

Week

8

**Start date**

Applicant is informed of service detail and start date.

**Onward referral**

The intervention provided by Quest and RehabCare is time limited. Following completion of the Rehabilitative Programme onward referral and transition will occur as deemed appropriate.