# Quest Brain Injury Service

# Confidential Health Report

Quest Brain Injury Services
Part of National Learning Network

EUROPEAN QUALITY IN REHABILITATION

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

***For Office Use***

**Health Report received _____**

## To be completed by Applicant

Name: _____

Address: _____

_____

_____

Date of Birth: _____

Phone/Mobile: _____

email: _____

I have applied to The Rehab Group (Learning) for a training programme and I give my explicit consent for information on my medical condition and history to be made available to The National Learning Network.

*Signed:* _____ *Date:* _____

I would be grateful if you could complete and return this form as soon as possible to enable my application to be processed.

## To be completed by Applicant's Doctor

Medical Diagnosis/Condition:

Date of Onset:

Impact on daily life:

Would the individual benefit from taking part in ……?

Yes ❑ No ❑

**N.B.** It may be necessary to share the information on this page only with an Officer of the funding authority.

## Health Report

Please give details of any medication the person is receiving:

| Medication | What side effect may the person experience? |
|---|---|
| | |
| | |
| | |
| | |
| | |

If this person has a condition where relapse is a feature, please indicate the pattern of relapse and likely symptoms indicating its onset:

| Medical Condition | Pattern of Relapse |
|---|---|
| | |
| | |
| | |
| | |
| | |

Does this person have a medical condition that requires health and safety practices?

Yes ❑ No ❑ Not known ❑

If yes, please give details:

| Medical Condition | Health & Safety Practices |
|---|---|
| | |
| | |
| | |
| | |
| | |

Have you referred this person to any other professional?
Psychologist, Psychiatrist, Social Worker, Occupational therapist, Speech or Language Therapist etc.

Name: _____
Job Title: _____
Address: _____
_____
_____
Phone/Mobile: _____
email: _____

Name: _____
Job Title: _____
Address: _____
_____
_____
Phone/Mobile: _____
email: _____

As far as you are aware, does this person have a history of?

| | | |
|---|---|---|
| Fire Setting | Yes ❑ | No ❑ |
| Self-Harm / Suicide Ideation | Yes ❑ | No ❑ |
| Inappropriate Sexual Behaviour | Yes ❑ | No ❑ |
| Alcohol / Drug Abuse | Yes ❑ | No ❑ |
| Aggressive / Violent Behaviour | Yes ❑ | No ❑ |

If the answer is **yes** to any of the above, please give details:

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

Please give details of any other information which may be relevant to this person's training and social/vocational rehabilitation.

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

## Signature of Medical Practitioner

Signature: _____

Profession: _____

Date of completion: _____

Address: _____

_____

Please place official stamp here:

Please return to;

Quest Brain Injury Services
9a Liosban Business Park
Tuam Road
Galway

Thank you for your help in providing this information.

## Data Protection

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