Quest Brain Injury Services

Part of National Learning Network

APPLICATION FORM
For
Mayo and Roscommon

Personal Details

First Name		Home Phone No:	
Surname		Mobile Phone No:	
Address:		Email Address:	
		Date of Birth:	
		Gender	

Next of Kin / Contact Person	
Address:	
Home Phone Number:	
Mobile Phone Number:	
Relationship to Applicant:	

Marital Status

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

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

____

____

____

Current Accommodation: (living alone, with family etc.)

____

____

____

Social Welfare Benefits

Are you receiving any of the following benefits?

- ❑ Disability Allowance (DA)
- ❑ Blind Person's Allowance (BPP)
- ❑ Invalidity Pension (IP)
- ❑ Disability Pension (DB)
- ❑ Jobseeker's Allowance (JA)
- ❑ Jobseeker's Benefit (JB)
- ❑ Lone Parent Recipient (LPR)
- ❑ Lone Parent Recipient with Disability
- ❑ Other

Are you registered with SOLAS? Yes ❑ No ❑

Do you have a Travel Pass? Yes ❑ No ❑

Disability Profile / Health Status:

Date of Brain Injury:_________________

Cause of Brain Injury: _________________

Was there any loss of consciousness? Yes ❑ No ❑

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

____

____

____

____

____

Please describe how this affects you:

____

____

____

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

Medication	Side Effects

Please complete the following, in case of accident of illness:

Name of G.P ____

Address: ____

____

____

____

Phone No: ____

Please list any other professionals you are involved with:
(Consultant, Occupational Therapist, Social Worker, Community Health Nurse etc.)

Name: ______________________ Name: ______________________

Job Title: ______________________ Job Title: ______________________

Address: ______________________ Address: ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Phone: ______________________ Phone: ______________________

Name: ______________________ Name: ______________________

Job Title: ______________________ Job Title: ______________________

Address: ______________________ Address: ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Phone: ______________________ Phone: ______________________

Please list any supports you require: (wheelchair access, interpreter, personal assistant, adaptive equipment etc.)

____
____
____

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

Name: ______________________ Job Title: ______________________

Phone: ______________________ Email: ______________________

Address: ______________________ Relationship to Applicant ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

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Additional Information:

SPECIALIST REPORTS What reports are available? Please provide copies if possible.			
General Medical	❑	Community Care Assessment	❑
Neurosurgical	❑	Occupational Therapy	❑
Neurology	❑	Physiotherapy	❑
Psychiatric	❑	Speech Therapy	❑
Neuropsychological	❑	National Rehabilitation Hospital	❑
Employment Service	❑	Other Residential Service	❑

Signed: _______________ Date: _______________

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Consent to be *signed* by the person i.e. Applicant

The referral process and subsequent Quest Rehabilitative Programme requires the applicants consent to the release of information and authorisation of discussion between Care/Service providers (Please discuss this with the client).

<table>
<tr><td>1.</td><td>I give my consent for relevant information (as outlined above) to be passed to QUEST.</td></tr>
<tr><td>2.</td><td>I authorise QUEST to exchange relevant information with approved agencies towards securing placement on this programme.</td></tr>
<tr><td>3.</td><td>I understand that this exchange of information will be ongoing throughout the duration of my Quest Programme.</td></tr>
<tr><td>4.</td><td>I consent to my Family Member/Significant Other (Name:………………….……….........) being involved in my Rehabilitative Programme.</td></tr>
<tr><td colspan="2">I authorise the storage of such information and/or reports to be maintained securely by Quest Brain Injury Services on the basis that the information will be stored and disclosed in accordance with the Data Protection Acts 1988 and 2003.</td></tr>
<tr><td colspan="2">Name:</td></tr>
<tr><td colspan="2">Signature: Date:</td></tr>
</table>

Please return this completed form to:

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