Galway Acquired Brain Injury (GABI)

Referral Form

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quest Brain Injury Services
Part of National Learning Network

RehabCare
Investing in People, Changing Perspectives

Personal Details

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

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

What services do 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.*	

Marital Status

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

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

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

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

Are you registered with Solas? Yes ❑ No ❑

Do you have a Travel Pass? Yes ❑ No ❑

Disability Profile / Health Status:

Date of Head Injury:___________________

Was there any loss of consciousness Yes ❑ No ❑

What was the nature of the brain injury?

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

Do you self administer medication? Y ❑ N❑
Do you require support to administer medication? Y ❑ N❑
Do you have any allergies? Y ❑ N❑

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.)

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

Name: ____________________ Job Title: ____________________

Phone: ____________________ Email: ____________________

Address: ____________________ Relationship to Applicant ____________________

____________________ ____________________

____________________ ____________________

Additional Information:

SPECIALIST REPORTS What reports are available?		Have you enclosed?	
General Medical	❑	Community Care Assessment	❑
Neurosurgical	❑	Occupational Therapy	❑
Neurology	❑	Physiotherapy	❑
Psychiatric	❑	Speech Therapy	❑
Neuropsychological	❑	National Rehabilitation Hospital	❑
Employment Service	❑	Other Residential Service	❑

Signed: __________________ **Date: __________________**

Office use	
MDT assessment	
Quest	
Rehabcare	
Joint	
Outreach support hours	
Residential	

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

The referral process and subsequent Quest/Rehabcare Rehabilitative Programme requires the clients 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/RehabCare.</td></tr>
<tr><td>2.</td><td>I authorise Quest/RehabCare to exchange relevant information with approved agencies towards securing placement with the service.</td></tr>
<tr><td>3.</td><td>I understand that this exchange of information will be ongoing throughout the duration of my service/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 Rehab Group 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 with your application form:

Please return to:
The Disability Services Department
c/o Galway services ABI Clearing House
Merlin Park Hospital
Galway

GALWAY ABI SERVICES STEP BY STEP APPLICATION PROCESS