ACQUIRED BRAIN INJURY IRELAND

STEP AHEAD PLUS Vocational Assessment and Rehabilitation Referral Form

Acquired Brain Injury is an injury to the brain that has occurred after birth. This can occur as a result of, e.g.: a Fall, Assault, Accident, Infection, Stroke, Tumour, Concussion or a Road Traffic Accident.

WHEN COMPLETING THIS FORM, PLEASE USE BLOCK CAPITALS AND FILL IN AS MUCH DETAIL AS POSSIBLE

Referral Criteria

To be eligible for referral to the service, the person being referred MUST, at a minimum, meet the following criteria. Please tick.

- ☐ Have a primary diagnosis of an Acquired Brain Injury
- ☐ Medically stable
- ☐ Referred by any Healthcare Professional or relevant organisation who can confirm an acquired brain injury diagnosis; or if you are self-referring, you must provide a document confirming you have an acquired brain injury diagnosis e.g. medical report or discharge letter
- ☐ Willing to engage in a vocational assessment with the aim of returning to work, training or education

If you have answered No to any of the above, the person may not be suitable for the service so please contact us to discuss the referral before proceeding.

Please Note: Our service is conducted primarily via tele-health (video/phone/email support). Firstly we carry out an initial interview via video call and the person may then be invited for an in-depth face-to-face vocational assessment in one of our 3 centres (Dublin, Cork, or Midlands). If deemed suitable, the person may then be offered vocational rehabilitation via tele-health. The service is not suitable for people with degenerative conditions, with progressive organic disorders or with Alcohol Related Brain Injury.

Personal Details

Full Name:

Address:

Home Tel Number:

Mobile Number:

Email:

Date of Birth: Age: yrs

Gender: ☐ Male ☐ Female ☐ Prefer not to say

Health Service Executive Area:

GP

Name:

Address:

Tel Number:

Mobile Number:

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Details of Acquired Brain Injury (ABI)

Use additional page if required. Please provide any recent medical or therapy reports that are relevant to this referral.

Date of Injury: / /

Cause of Injury:

Circumstance of Injury: ☐ Home ☐ Work ☐ Sport ☐ Other:

Traumatic Brain Injury:

e.g. Road Traffic Accident, Fall:

Diagnosis:

Non Traumatic Brain Injury:

Vascular Accident:

Infection:

Cerebral Anoxia/ Hypoxia:

Other inflammation of the brain:

Discretionary Information:

This information is **NOT mandatory**. Please give the person the option to volunteer the information.

If they choose NOT to disclose this information they will NOT be excluded from accessing the service.

Has the person being referred history of substance use? ☐ Yes ☐ No

If Yes, send details of treating physician / current support plan with referral if available

If current, has the person completed a voluntary period of abstinence of at least 3 months? ☐ Yes ☐ No

If previous, has the person completed a Rehabilitation Programme? ☐ Yes ☐ No

Has the person being referred a history of psychiatric illness? ☐ Yes ☐ No

If Yes, send details of treating physician / current support plan with referral if available

Please give details of any other risks associated with this referral that the person chooses to disclose

Primary Difficulties

Column 1: Please rate the 8 domains in terms of impact on functioning with:

3 being the area of most impact, 2 being an area of significant impact and 1 being a minor impact area for this person.

Column 2: Circle the areas impacted

Column 1	Column 2
☐ Thinking Skills:	Memory, Concentration, Planning, Organising, Decision Making, Orientation, Insight.
☐ Communication:	Language Expression, Language Comprehension, Turn Taking, Social Skills.
☐ Behaviour:	Impulsive, Disinhibited, Irritable, Aggressive, Passive.
☐ Mood:	Tearfulness/Depression, Mood Swings, Worry/Anxiety, Reduced Confidence, Suicidal.
☐ Physical:	Wheelchair, Poor Mobility, Hemiparesis, Weakness, Balance, Fatigue, Pain, Seizures, Diabetes.
☐ Sensory:	Problems With Eyesight, Hearing, Sensitivity to Touch, Sense of Smell, Sense of Taste.
☐ Basic Care:	Incontinence, Personal Hygiene, Toileting, Self-Medication, Independence, Eating & Drinking.
☐ Social:	Reduced Social Network, Relationship Difficulties, Sexual Difficulties, Isolation, Lack of Meaningful Activity / Supports, Lack of Structure / Routine.

Educational Information

Highest Level of Education:

Is the person currently in Full or Part Time Education? ☐ Yes ☐ No

If yes, please give details of Location, Level and Stage:

Vocational Information

Employed at time of injury? ☐ Yes ☐ No

Type and duration of employment:

What is the person's reason for referral? Return to work, training, education or are they unsure at the moment?

Professional Agencies / Services Currently Involved

Please continue on a separate sheet if required and/or add in relevant reports.

Past therapy services attended (e.g. Occupational Therapy, Physiotherapy, Speech & Language Therapy, Psychology, etc.)

Current therapy or support services (e.g. Occupational Therapy, Physio, Speech & Language Therapy, Psychology, Rehab Assistant, Personal Assistant, HSE service, Case Manager, Day Service etc). Please provide contact details.

If the client is currently engaged with your service, please outline current goals.

Referral Details – All details must be filled in.

Date of Referral: / /

Name of person completing this form:

Signature of person completing this form:

Relationship to person referred:

Agency/Organisation (where relevant):

Address:

Contact phone number:

Contact email address:

Release of Information

Please note that we cannot process referrals unless they are accompanied by written informed consent to the release of information and authorisation of discussion between care/ service providers.

Please Return This Form To:

Katie O' Dwyer
Area Administrator, Acquired Brain Injury Ireland,
National Services (Area 2), St Luke's Hospital,
St Theresa's Wing, Western Road, Clonmel,
Co Tipperary, E91PR83

ACQUIRED
BRAIN INJURY
IRELAND

Release of Information

Name: ....

Date of Birth: ....

I hereby give consent to Step Ahead Plus, Acquired Brain Injury Ireland to share information with a third party from my vocational report / personal progression plan and occupational history. I understand that this information may be used to assess the suitability of other services to my needs / to tailor services to my needs / in the provision of services.

I understand that I may revoke this consent at any time by writing to Acquired Brain Injury Ireland. If information has already been released based on my consent, my request to stop the consent will not apply to information already released.

.... Date: .... / .... / .... (dd/mm/yyyy)

Signature of Person

If the person referred is unable to sign the consent form, it may be signed below on their behalf by a nominated representative.

I have discussed the above information about the provision of consent with (name of referred individual) .... I can confirm that he/she wishes to give consent to Acquired Brain Injury Ireland to release his/her background information to relevant organisations/individuals. I can also confirm that he/she understands that he/she can revoke this consent at any time.

.... Date: .... / .... / .... (dd/mm/yyyy)

Signature of Nominated Representative

....

Relationship to Person Referred
(i.e. Next of Kin, Next Friend, Parent or Legal Guardian)

In line with the Data Protection Act 2003, any information received by or disclosed by Acquired Brain Injury Ireland about individuals (including electronic information) will only be held with regards to the intended purpose i.e. to assess a referred person's needs in order to identify if and how Acquired Brain Injury Ireland can meet their needs. If the person referred is offered a service, the assessment information will remain on the individual's file.

Miscellaneous information will be gathered and used by the organisation to monitor the demand for service; we may also use this to inform organisational development and business priorities.

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