ACQUIRED BRAIN INJURY IRELAND

Step Ahead Plus Referral Form

Before you fill in this form, please read our information leaflet, About the Step Ahead Plus Service for People with Acquired Brain Injury.

Please use BLOCK CAPITALS when you fill in this form.

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:

Home Tel Number:

Mobile Number:

Who is referring you?

Please tick the boxes that apply.

I am referring myself. ☐

I have attached a letter or report that confirms that I have an acquired brain injury. ☐

If you are referring yourself, you **must** attach a letter or report about your brain injury.

I am being referred by a healthcare professional. ☐

Name and job title of my healthcare professional:

Medical report/discharge summary included . ☐

Do you meet these conditions?

Are you medically stable? (This means you are not having medical treatment now.)	Yes ☐	No ☐
Do you want to have your skills and abilities assessed to help you return to work, training or education?	Yes ☐	No ☐

If you answered yes to each question, please finish filling in this form and send it to us.

If you answered no to one or more questions, this might not be the right service for you. Please do not send us this form. Instead, please contact us to discuss your needs.

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:

Why would you like to take part in Step Ahead Plus?

Please answer each question by putting a tick mark in the appropriate column.

	YES	NO	Please give further details
I have a job or education course to return to (Please indicate timeframe of your planned return, job title or course title) ☐ less than a month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ more than 12 months	☐	☐	
I have returned to work or education, but I am experiencing challenges	☐	☐	
I am currently on sick leave	☐	☐	
I am self-employed	☐	☐	
I am interested in having paid employment	☐	☐	
I am interested in volunteering	☐	☐	
I am interested in going back to education	☐	☐	

Optional information

Answering these questions is optional. If you qualify for the service, we will still include you if you do not answer these questions.

Question	YES	NO
Do you have a history of drug or alcohol misuse?	☐	☐
If you currently misuse drugs or alcohol, have you stopped using them for at least 3 months by your own choice?	☐	☐
If you misused drugs or alcohol in the past, have you completed a rehabilitation programme?	☐	☐
Do you have a history of psychiatric illness?	☐	☐

If you answered yes to any questions in this section, please include the contact details of the doctor you are seeing and a copy of any written support plan that you have.

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.

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:

Before you proceed with this referral, please complete the **Consent Form for Step Ahead Plus** document and the **nominated consent form** must also be completed.

Please send the referral form and consent form to:

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

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ACQUIRED BRAIN INJURY IRELAND

Consent Form for **Step Ahead Plus**

Please read the information below and sign this form if you consent to sharing information with Step Ahead Plus – assessment and rehabilitation service.

- I give my permission to Acquired Brain Injury Ireland (ABII) to collect information on my clinical, educational, and work history. I understand that they need to collect my information to provide me with their Step Ahead Plus Service.
- I understand that ABII will keep my information on a secure electronic database and in a paper copy that is kept safe.
- I understand that ABII will not share my information and assessment report with anyone outside of ABII without my consent.
- If I want to withdraw my consent, I will write to ABII to tell them.
- If I withdraw my consent, it will not apply to my information that has already been shared.
- My information, written and electronic, will be held only for use by the Step Ahead Plus service. If I am offered a service, my information will be kept on file. This is in line with the Data Protection Act 2003.
- ABII might use my information to help them monitor the demand for the services so they can develop the organisation.
- Data from outcome measurement may be used by ABI Ireland for audit and research purposes but the person served will not be personally identifiable in any publication.
- If I cannot sign this form myself, I can choose someone to sign it for me.

Please tick the relevant box for this statement.

I agree to Acquired Brain Injury Ireland collecting and storing my information. YES ☐ NO ☐

Your signature

Name (Block letters): .....

Signature: ..... Date: ..... ▶

Signature of your representative if you cannot sign this form yourself

Name (Block letters): .....

Signature: ..... Date: .....

Your relationship to the person consenting (circle one): **Next of kin** | **Next friend** | **Parent** | **Legal guardian**

Reg charity no. 20046200 | CHY14289

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ACQUIRED BRAIN INJURY IRELAND

Consent to Record/Release Nominated Person Contact Details:

Name of Person Referred:

Date of Birth: / / (dd/mm/yyyy)

If your contact details have been included as a Nominated Person, it is necessary for us to capture your consent to hold your information and to release your information only when relevant to the individual's rehabilitation. This is necessary to provide rehabilitation and to protect the vital interests of the person served.

We will not share your information with third parties for marketing purposes or promotions. For more information please see our Privacy Policy at **https://www.abiireland.ie/privacystatement**.

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.

I hereby give consent to Acquired Brain Injury Ireland to process my personal data in accordance with the above.

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 2018, any information (including electronic information) received by or disclosed by Acquired Brain Injury Ireland about individuals 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. Anonymised information will be used by the organisation to monitor the demand for services and to monitor the effectiveness of the service. We may also use this to inform organisational development and business priorities and to publish anonymised service outcomes.

Date for consent review: (Office Use Only)

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