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 . ☐

Reg charity no. 20046200 | CHY14289

## 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:**

## 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. |

Other information about your difficulties. Please include any details that may help us understand your situation and process your referral.

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## 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.

## 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)<br>☐ less than a month ☐ 1-3 months<br>☐ 3-6 months ☐ 6-12 months<br>☐ more than 12 months | ☐ | ☐ | |
| I am currently on sick leave<br>(Please give details of any occ. health assessment completed and length of time signed off if known) | ☐ | ☐ | |
| I have returned to work or education, but I am experiencing challenges | ☐ | ☐ | |
| I am self-employed | ☐ | ☐ | |
| I am interested in having paid employment | ☐ | ☐ | |
| I am interested in volunteering | ☐ | ☐ | |
| I am interested in going back to education | ☐ | ☐ | |

## Have you been referred to or are you being seen by another service?

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

| | YES | NO | Please give further details |
|---|---|---|---|
| Acquired Brain Injury Ireland Community Services | ☐ | ☐ | |
| HSE Community Rehab Team or Primary Care | ☐ | ☐ | |
| NRH-Vocational Assessment | ☐ | ☐ | |
| NRH-Other service | ☐ | ☐ | |
| Psychology service | ☐ | ☐ | |
| Headway | ☐ | ☐ | |
| Quest | ☐ | ☐ | |
| Other service not listed | ☐ | ☐ | |

## **Referral Details** – All details must be filled in.

| | |
|---|---|
| Date of Referral: | Address: |
| Name of person completing this form: | |
| Signature of person completing this form: | |
| Relationship to person referred: | Contact phone number: |
| Agency/Organisation (where relevant): | Contact email address: |

Before you proceed with this referral, please complete the **Consent Form for Step Ahead Plus** document and the **Consent Form to Release Emergency Contact Details** 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.

This project was approved by Government with support from the Dormant Accounts Fund.

# 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**

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# Consent Form to Release Emergency Contact Details

Please read the information below and sign this form if you consent to releasing your details as an emergency contact.

We ask for contact details of a person that we can contact in the unlikely event of an emergency. This is called an Emergency Contact. An example of an emergency would be where the person becomes ill during a session with a Step Ahead Plus staff member and we would phone the emergency contact to let them know. This is usually a family member, close friend, or trusted neighbour.

Please tick the relevant box for this statement. I agree to Acquired Brain Injury Ireland collecting and storing my information. I give my permission to Step Ahead Plus, Acquired Brain Injury Ireland (ABI Ireland) to hold my name and contact information which may be used in the event of an emergency relating to the person being referred to Step Ahead Plus.

- I understand that ABII will keep my information on a secure electronic database and in a paper copy that is kept safe.
- My information, written and electronic, will be held only for use by the Step Ahead Plus service. This is in line with the Data Protection Act 2003.
- I understand that ABII will not share my information 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.
- 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 ☐

## Signature of Emergency Contact

Name of Emergency Contact (Block letters): ..............................................

Signature of Emergency Contact:

Phone number of Emergency Contact:

Date:

Your relationship to the person being referred (circle one):

Next of kin | Next friend | Parent | Legal guardian.

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