Application For Service

Please fill in this form as completely as you can. This will reduce any delays in processing your application. Q6 is optional - you can choose to answer it if you like. If you need help filling in the form, please contact Headway Information and Support on 1800 400 478. Please write all information using CAPITAL LETTERS.

Q1. About the person completing the form

a) Are you completing this form for someone else? (Please tick one)

Yes ☐ → Please continue on this page

No. I am applying for Headway services myself ☐ → Now turn to the next page, Q3

Q2. Your relationship to the person seeking services

a) Your name

b) What is your relationship to the person with brain injury?

Spouse or Partner ☐
Family Member ☐
Friend ☐
Carer ☐
Professional ☐
Other (please specify) ☐

c) Agency name and role, if professional

d) Mobile or telephone

e) Do we have your permission to contact you via Text Message for the purpose of providing Headway Services? Yes ☐ No ☐

f) Your email address

g) Do we have your permission to contact you using your email address for the purpose of providing Headway Services? Yes ☐ No ☐

h) Your contact address

i) How did you hear about Headway?

Return to: Referrals Coordinator, Headway, 9-11 Upper William Street, Limerick, V94 K702

Q3. Name and contact information of the person seeking services

a) Name

b) I am: Male ☐ Female ☐ Other ☐ c) Date of Birth: / /

d) Address at time of injury e) Current Address - If same as d), tick ☐

f) Home phone

g) Mobile phone

h) Do we have your permission to contact you via Text Message for the purpose of providing Headway Services? Yes ☐ No ☐

i) Email address

j) Do we have your permission to contact you via email for the purpose of providing Headway Services? Yes ☐ No ☐

Q4. Who can we contact in an emergency?

Please give the name of a family member, carer or friend as your emergency contact

Name: Relationship

Address:

Telephone:

Email:

Q5. GP details

Name of GP

GP Telephone

Address of GP

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Q6. Language and cultural background (optional question)

Why have we included this question? Your answers help us to develop better services. We use them only to ensure that our services reflect the backgrounds of the people we serve.

a) Country of Origin

b) Can you speak English? Yes ☐ No ☐

c) First language – spoken at home:

English ☐
Irish ☐
Other (please state) ☐ _____

d) Ethnic or cultural Background

White Irish ☐
White Non-Irish ☐
Irish Traveller ☐
Black African ☐
Black Non-African ☐
Asian or Asian Irish (Chinese) ☐
Asian or Asian Irish (non-Chinese) ☐

Other (please state)

e) Religion
Christianity ☐
Islam ☐
No religion ☐
Rather not say ☐
Other

Q7. Living, working and social situation

Please tick all that apply:

Live alone ☐
Live with parents ☐
Live with spouse or partner ☐
Live in permanent accommodation ☐
Live in temporary accommodation ☐
Currently employed ☐
Currently engaged in training ☐

Activities you are involved in, for example: volunteering; sports; social clubs:

Q8. Details of the Acquired Brain Injury (ABI)*

Date of Injury: / /

*If more than one injury, use most recent

Please specify the cause of injury, Please tick all that apply.

Road Traffic Accident ☐
- Vehicle Driver ☐
- Vehicle Passenger ☐
- Bicycle ☐
- Motorcycle ☐
- Pedestrian ☐

Fall ☐

Sporting Accident ☐

Assault ☐

Other (please specify)

Stroke ☐
- Haemorrhage (bleed) ☐
- Meningitis or Encephalitis ☐
- Anoxia/Hypoxia (lack of oxygen) ☐
- Tumour removal ☐
- Alcohol-Related Brain Injury ☐

Have you been diagnosed with any degenerative, progressive or deteriorating conditions? If yes, please give details

Yes ☐ No ☐

Q9. Hospitals or centres and services attended

Please provide the names and addresses of the hospitals or centres attended since injury.

Name and address of hospital or centre	Date from - to	Name of consultant or professional

Return to: Referrals Coordinator, Headway, 9-11 Upper William Street, Limerick, V94 K702

Q10. Current needs and difficulties

Do you need help with any of the following as a result of the brain injury?

Please tick all that apply.

a) Physical or sensory:

Vision	☐	Fatigue/Tiredness	☐
Hearing	☐	Epilepsy	☐
Weakness,	☐	Sexual difficulties	☐
Reduced Mobility	☐		

Other (please specify)

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b) Cognitive:

Attention	☐	Communication	☐
Memory	☐	Speech	☐
Planning	☐	Motivation	☐
Orientation	☐		

Other (please specify)

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c) Behaviour:

Irritability	☐	Impulsivity	☐
Aggression	☐	Inappropriate/Anti-Social behaviour	☐

Other (please specify)

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d) Emotion:

Mood Swings	☐	Anxiety	☐
Depression	☐	Reduced Confidence	☐
		Anger	☐

Other (please specify)

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e) Self-awareness and insight - Do other people tell you that you have more difficulties than you think you have? - Please give details

f) Personal needs or daily living tasks:

Eating	☐	Assistance with dressing when using the toilet	☐
Drinking	☐	Assistance with personal care when using the toilet	☐
		Number of people needed to assist _____	

Other (please specify)

Q11. Please list all current medication:

Q12. Do you have any history of substance abuse or addiction?

Alcohol ☐ Drugs ☐ Other – Please Specify:

What is your current status in relation to this?
E.g. actively using, abstinent, undergoing treatment for addiction.

Q13. Services other than Headway currently applied for or attending:

Service	Attending	Applied
	☐	☐
	☐	☐
	☐	☐

Q14. Reason for application

What is your reason for applying for Headway Services?

Any other information you wish to include:

Return to: Referrals Coordinator, Headway, 9-11 Upper William Street, Limerick, V94 K702

Q15. Declaration and consent to be signed by the person seeking services

a) Your medical history and records

1. I give consent for information on my medical and occupational history to be given to Headway.
2. I give consent for Headway to maintain all personal data concerning my medical and occupational history relevant to providing me with rehabilitative services.
3. I give consent for Headway to release reports and information on my rehabilitation and progress to my G.P or other professionals involved in my care.
4. I have read, and understood, the limits of confidentiality explained on page 8.

Signature of person seeking services _____

b) Fundraising

From time to time Headway may wish to contact you to inform you or your nominated family member of events and fundraising opportunities. Headway will not share this information with any other body or institution. Are you willing to be contacted in this way?

Yes, by:

Post ☐

Email ☐

Phone Call ☐

Text Message ☐

No, I don't want to be contacted ☐

Signature of person seeking services _____

Please return this completed form to:
Referrals Coordinator,
Headway,
9-11 Upper William Street,
Limerick,
V94 K702

Consent to share information with Mid-West ABI Referrals Committee

To ensure that your needs are appropriately met with the correct service, with your permission, the information on this form will be shared with the Mid West Referrals Committee.

This committee is comprised of representatives from Headway, HSE, Acquired Brain Injury Ireland (ABII) and the Community Neuro Rehabilitation Team (CRT). The purpose of this committee is to ensure that your needs are met with the correct service, which may be through any or a combination of the agencies listed.

Please fill in and sign the release of information form on page 9 to allow your referral to be discussed at the next Mid West Referrals Committee meeting.

Release of Information

Name of Person referred: _____ Date of Birth: _____

I give consent for Acquired Brain Injury Ireland, Headway, Health Service Executive and/or HSE Community Neuro Rehabilitation Team to:

- Discuss my referral at the Mid West ABI Referral Forum,
- Obtain information on my clinical, educational and occupational history and
- Release reports and information on my rehabilitation and progress to my G.P. and other clinicians/professionals involved in my care.

I understand that I may revoke this consent at any time by writing to Acquired Brain Injury Ireland, Headway, Health Service Executive or HSE Community Neuro Rehabilitation Team. If information has already been released based on my consent, my request to stop the consent will not apply to information already released.

New referrals are discussed at the Mid West ABI Referral Forum, so that the most appropriate service for the person's current needs can be determined. Information about the person's clinical, educational and occupational history may be used to assess the suitability of the services listed above to the person's needs, to tailor services to the person's needs and/or in the provision of healthcare services. These services will hold some of this information on a secure electronic database.

Signature of Person Referred: _____ Date: _____

Return to: Referrals Coordinator, Headway, 9-11 Upper William Street, Limerick, V94 K702

If the person referred wishes to give consent but is unable to sign the consent form, it may be signed below on their behalf by a 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, Headway, Health Service Executive and HSE Community Neuro Rehabilitation Teamto obtain his/her background information from relevant organisations/individuals. I can also confirm that he/she understands that he/she can revoke this consent at any time.

Signature of Representative: _____Date: _____

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

In line with the Data Protection Act 2003, any information (including electronic information) received by or disclosed by Acquired Brain Injury Ireland, Headway, Health Service Executive and HSE Community Neuro Rehabilitation Team 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 these organisations 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 organisations to monitor the demand for service; we may also use this to inform organisational development and business priorities.

Privacy Notice - Please read this important information

Protecting your personal information – the limits of confidentiality

Your personal information will always be treated with respect. Your data is kept confidential and secure and only used for the purpose of providing you with a service. We will not generally share your information with other people without your permission.

There are some rare occasions on which it may be necessary to share information about you without your permission. These occasions include:

- If it is necessary to prevent harm to you
- If it is necessary to prevent imminent harm to someone else
- If you tell us about a situation in which a person under the age of 18 or a vulnerable adult is, or may be in danger of, harm
- If we are required to do so by law, for example if ordered by Court, or required by Gardaí
- If necessary in the interest of public safety

Your rights

Under the the law, you have the right to:

- Access the information we hold about you.
- If you find that any of the information is incorrect, you also have the right to have it changed.
- You also have the right to have your information supplied in an electronically portable format.
- You can also request that your records be erased from our system.

To avail of your rights, you can download a personal data access request form from our website at headway.ie/privacy-policy/

Comments and complaints

You can make a complaint or comment about any aspect of Headway or its service – forms and policy are available from any member of staff or from our website at headway.ie/about-us/our-codes-policies/

More information

The full version of the Headway policy on Data Protection is available on request from any member of staff or from the Headway website at headway.ie/privacy-policy/

Please return this completed form to:

Referrals Coordinator, Headway, 9-11 Upper William Street, Limerick, V94 K702