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.

Q1. About the person completing the form

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

Yes, I am completing the form on behalf of someone else ☐

Continue on **this page**

No, I am applying for Headway services myself ☐

Now go to **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)

Role/Job Title

c) Please provide name of your agency, 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, Blackhall Green, off Blackhall Place, Dublin 7

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

Return to: Referrals Coordinator, Headway, Blackhall Green, off Blackhall Place, Dublin 7

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 ☐ Black Non-African ☐

White Non-Irish ☐ Asian or Asian Irish (Chinese) ☐

Irish Traveller ☐ Asian or Asian Irish (non-Chinese) ☐

Black African ☐

Other (please state)

e) Religion Christianity ☐ Rather not say ☐

Islam ☐ Other ☐

No religion ☐

Q7. Living, working and social situation

Please tick all that apply:

Live alone ☐ Live in permanent accommodation ☐

Live with parents ☐ Live in temporary accommodation ☐

Live with spouse/partner ☐ 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.

- Fall ☐
- Sporting Accident ☐
- Assault ☐
- Road Traffic Accident: ☐
  - Vehicle Driver ☐
  - Vehicle Passenger ☐
  - Bicycle ☐
  - Motorcycle ☐
  - Pedestrian ☐
- Stroke ☐
- Haemorrhage (bleed) ☐
- Meningitis or Encephalitis ☐
- Anoxia/Hypoxia (lack of oxygen) ☐
- Tumour removal ☐
- Alcohol-Related Brain Injury ☐

Other (please specify) _____

Have you been diagnosed with any progressive or deteriorating conditions such as Dementia, Parkinson's Disease, Multiple Sclerosis?

Yes ☐ No ☐ If yes, please give details

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	Dates (approx) from - to	Name of consultant or professional

Return to: Referrals Coordinator, Headway, Blackhall Green, off Blackhall Place, Dublin 7

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

Other (please specify)

b) **Cognitive:**

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

Other (please specify)

c) **Behaviour:**

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

Other (please specify)

d) **Emotion:**

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

Other (please specify)

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 ☐
Drinking ☐
Assistance with dressing when using the toilet ☐
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?

Yes ☐ No ☐ 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, Blackhall Green, off Blackhall Place, Dublin 7

Q15. Declaration and consent to be completed 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 released 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

I agree ☐ **My name** _____ **Date** _____

b) Contact permission for fundraising opportunities

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 ☐

I agree ☐ **My Name** _____ **Date** _____

How to send
Check you have ticked the boxes "I agree"

Electronically
Use File, Save As, name the file and email it to us at info@headway.ie

By Post
Please return this completed form to:
Referrals Coordinator,
Headway,
Blackhall Green, off Blackhall Place
Dublin 7

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 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 https://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 https://headway.ie/about-us/ourcodes-policies/

Use of information in legal cases

Work carried out at Headway is not intended for and should not be used for medico-legal purposes.

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 https://headway.ie/privacy-policy/

Please return this completed form to:
Referrals Co-Ordinator, Headway, Blackhall Green, off Blackhall Place, Dublin 7 or via email to info@headway.ie