

## Step Ahead Plus Referral Form

Please use BLOCK CAPITALS when you fill in this form.

See our webpage for more details on our programme:

[www.abiireland.ie/our-services/what-we-do/step-ahead-programme/](http://www.abiireland.ie/our-services/what-we-do/step-ahead-programme/)



### 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

Are you ready to consider returning 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:

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.....

.....

Diagnosis:

.....

.....

.....

### Non Traumatic Brain Injury:

Vascular Accident:

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.....

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: <input type="checkbox"/>	Memory, Concentration, Planning, Organising, Decision Making, Orientation, Insight.
Communication: <input type="checkbox"/>	Language Expression, Language Comprehension, Turn Taking, Social Skills.
Behaviour: <input type="checkbox"/>	Impulsive, Disinhibited, Irritable, Aggressive, Passive.
Mood: <input type="checkbox"/>	Tearfulness/Depression, Mood Swings, Worry/Anxiety, Reduced Confidence, Suicidal.
Physical: <input type="checkbox"/>	Wheelchair, Poor Mobility, Hemiparesis, Weakness, Balance, Fatigue, Pain, Seizures, Diabetes.
Sensory: <input type="checkbox"/>	Problems With Eyesight, Hearing, Sensitivity to Touch, Sense of Smell, Sense of Taste.
Basic Care: <input type="checkbox"/>	Incontinence, Personal Hygiene, Toileting, Self-Medication, Independence, Eating & Drinking.
Social: <input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
If you currently misuse drugs or alcohol, have you stopped using them for at least 3 months by your own choice?	<input type="checkbox"/>	<input type="checkbox"/>
If you misused drugs or alcohol in the past, have you completed a rehabilitation programme?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of psychiatric illness?	<input type="checkbox"/>	<input type="checkbox"/>

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?

Are you currently experiencing challenges in your current work or education?

YES  NO

OR

Do you have a job or education place to return to?

YES  NO

If yes, you may be eligible for the **Fast Track programme**.

This programme is delivered one-to-one. It is designed to support you to remain in or return to pre-existing work or education.

Please answer the following questions that are relevant to your situation.

1. Are you already in work or education and experiencing challenges due to your brain injury?

YES  NO

If Yes please explain the challenges: .....

.....

2. What is your estimated timeframe of your planned return to work or education?

Less than a month  1-3 months  3-6 months  6-12 months  More than 12 months

**Note – Please do not skip this question** if you are currently progressing back to work. It is important for our screening process.

3. If you are returning to work/education soon, what are the areas you are most concerned with? .....

.....

4. Are you on sick leave?

YES  NO

If yes please give details of any occupational health assessment completed and length of time signed off if known.

.....

5. Are you self employed?

YES  NO

.....

Are you seeking new employment or education?

YES  NO

If yes, you may be eligible for the **New Track programme**. These are online group sessions.

We share information and resources that you can use to explore your work or education options.

Please give details of the reason for your referral? .....

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See our webpage for more details on New Track and Fast Track  
[www.abiireland.ie/our-services/what-we-do/step-ahead-programme/](http://www.abiireland.ie/our-services/what-we-do/step-ahead-programme/)



## 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	<input type="checkbox"/>	<input type="checkbox"/>	
HSE Community Rehab Team or Primary Care	<input type="checkbox"/>	<input type="checkbox"/>	
NRH-Vocational Assessment	<input type="checkbox"/>	<input type="checkbox"/>	
NRH-Other service	<input type="checkbox"/>	<input type="checkbox"/>	
Psychology service	<input type="checkbox"/>	<input type="checkbox"/>	
Headway	<input type="checkbox"/>	<input type="checkbox"/>	
Quest	<input type="checkbox"/>	<input type="checkbox"/>	
Other service not listed	<input type="checkbox"/>	<input type="checkbox"/>	

## 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.



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## 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**



## 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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