Doorway to Life (Abode)

Kilbrack Grove, Skehard Road, Blackrock, Cork.
Telephone 021 4916180

DAY SERVICE APPLICATION FORM

INCOMPLETE APPLICATION AND CONSENT FORMS CANNOT BE PROCESSED. PLEASE USE BLOCK CAPTALS

Abode is not a medical / nursing facility and therefore is not in a position to provide active medical or nursing care.

COMPLETED FORMS SHOULD BE RETURNED TO THE SERVICE MANAGER, AT THE ABOVE ADDRESS

Date of Application	

PERSONAL DETAILS

Surname		
First Name		
Date of Birth		
Address		
Contact Numbers	Home	Mobile
PPS NUMBER		

MEDICAL CARD HOLDERS

Do you hold a Medical Card	Yes No
Medical Card Number	

SOCIAL WELFARE PAYMENT TYPE

Disability Allowance, Benefit etc	

DAY SERVICES

Please confirm if you avail of any other day services, and how often you have access to these services.

HOBBIES AND INTERESTS

Please indicate any hobbies or interests that you may have.

NATURE OF DISABILITY (please tick where appropriate)

Physical Disability	**Ongoing Illness**
Visual Impairment	**Dyslexia**
Hearing Impairment	**Other, give details**
Acquired Disability	

Please tick the services or supports that are currently being received:

FAMILY	**GP**	**NEIGHBOURS**
PUBLIC HEALTH NURSE	**HOME HELP**	
PERSONAL ASSISTANT	**PHYSIOTHERAPIST**	
VOLUNTARY ORGANISATION		
OCCUPATIONAL THERAPIST		
OTHER. Please specify		

CONTACT DETAILS

EMERGENCY CONTACT

Name	
Address	
Relationship	
Home Phone	
Mobile Phone	

NEXT OF KIN

Name	
Address	
Relationship	
Home Phone	
Mobile Phone	
Name	
Address	
Relationship	
Home Phone	
Mobile Phone	

REFERRAL AGENCY

Name	
Address	
Phone No	
Staff Contact	
Mobile No	

Public Health Nurse, Occupational Therapist, Physiotherapist etc

Name	
Address	
Phone	
Name	
Address	
Phone	
Name	
Address	
Phone	
Name	
Address	
Phone	

LEVEL OF INDEPENDENCE (please tick)

	Independent	Need Assistance	Dependent
Dressing / Undressing			
Bathing / Personal Hygiene			
Going to the toilet			
Bladder &Bowel Care			
Communicating			
Eating			
Shopping			
Safety with appliances			
Managing Money			
Preparing Meals			
Planning / going on outings / appointments			

AIDS AND APPLIANCES (please tick which of the following you use, if any)

	Often	Sometimes	Never
Walking Aid			
Electric Wheelchair			
Self-Propelled Wheelchair			
Assistive Technology			
Eating Utensils			
Hoist			
Shower Chair			
Shower Bed			
Transfer Board			
Transfer Belt			
Gripper			

WORK AND EDUCATION

Work Experience
Please outline your previous work experience. This may include full or part – time employment, work placements or voluntary work.

Employer	Address	Dates	Job title / role

Education
Please outline below details of your education to date, including a detailed description of any educational awards you have received.

Third Level / Post Leaving Certificate Courses

College	**Course**	**Dates**	**Educational Awards**

Secondary Education

School	**Dates**	**Subjects Studied**	**Educational Awards**

Primary Education

School	**Dates**

CONDITIONS OF APPLICATION

It is important that this application form is completed fully and accurately before returning it to Abode. All particulars should be entered in BLOCK CAPITALS except signatures.

Abode is NOT a medical / nursing facility and is not equipped or staffed as such. Applicants who need active medical treatment or nursing care cannot be catered for at Abode. An assessment of needs will be carried out prior to an applicants admission.

In the event of a deterioration in the service users condition after admission, arrangements must be made by the Carer/Next of Kin and/or Referral Agency named on this form to have the applicant transferred from Abode. Should you become ill and need to be admitted to hospital while staying at Abode we will endeavour to ensure that, if staff levels allow, a staff member remains with you until such time as they are relieved by your next of kin who will be contacted at the earliest opportunity.

A person leaving the premises must inform staff of their departure and sign out. They must also inform staff of the expected time of return.
All special appliances required by the applicant, such as continence products etc **MUST be supplied by the applicant upon admission**.

Please read the following and sign below:

We, the applicant, carer/next of kin and referral agency (where applicable) have read and understood the particulars in this application form. We agree to abide by the conditions of admission.

Signatures:	
Applicant	
Next of Kin	
Referral Agency	
Date	

STATEMENT OF
CONSENT TO SHARE INFORMATION

NAME
DATE OF BIRTH

Please read this carefully, complete the restriction box if appropriate and then sign, and date the form. If you have any concerns please discuss them with a member of staff.

I **agree** that the information provided in my application may be shared with Abode staff, and other service providers who may contribute to my care and support. I understand that other agencies may be asked for information about me.

I **understand** that this information will be used for the purpose of providing the most appropriate services, or supports to me.

I also **understand** that agencies may use anonymised information for statistical purposes and that the law may allow in some circumstances for other agencies to be provided with information about me.

I **understand** that I may withdraw my consent to share information at any time and this may result in a review of the services being available.

I **understand** that my information will be held securely on paper and on computer in accordance with the Data Protection Acts.

I understand that I have the right to restrict what information may be shared and with whom. **I make the following restrictions to sharing of information about me:** (if applicable)

Signature	**Print Name**
Date	

In order to alter your consent, please contact the staff member you have most contact with.

MEDICATION CONSENT FORM

If you require medication please ensure that you submit a prescription appropriate for the duration of your stay three weeks before you are due to visit. Abode reserves the right to refuse access to the service if prescriptions are not provided within the required time frame.

Your medication will be dispensed, by Abode staff, biodosed from our local pharmacy.

All monies owing to the pharmacy for your prescription must be paid <u>prior</u> to departure.

Please sign below to confirm acceptance of these terms, and to your medication being administered by Abode staff.

I, _____, consent to having my medication administered by Abode staff while staying for a respite break.

Signature	
Date	

MEDICAL REPORT
(to be completed by applicant's Doctor)

Applicants Name	

Doctors Details	
Name	
Address	
Phone	
E-Mail	
Applicant's Medical or Drug Payments Card Number	
Doctor's Registered Number on card	
Date of most recent hospital stay.	
Medical History / Diagnosis	
Current medications (including time and administration route for each)	
Has the applicant any other underlying conditions? (epilepsy, a heart condition, asthma, pressure sores, ulcers etc.) Please give a brief outline and list any medication used.	
Please advise of any open wounds and confirm appropriate dressings.	

Has the applicant a history of psychiatric illness or challenging behaviour?
Is the applicant allergic to any medications?
Is the applicant allergic to any foods?
Does the applicant require a special diet or have specific dietary needs eg, drinks with a straw, uses thickener in liquid, difficulty swallowing etc?
Does the applicant require assistance or supervision in taking medication?
Please advise if the applicant has ever had or been in contact with any of the following. Hepatitis B or C MRSA HIV Glandular Fever Any other infectious or contagious disease.

Please detail any special appliances used by the applicant, e.g. conveens, catheters, drainage bags etc., together with required sanitary / continence products.

Any other comments or observations?

DOCTORS SIGNATURE **DATE**
DOCTORS STAMP