Doorway to Life (Abode)

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

TRAINING APPLICATION FORM

PLEASE USE BLOCK CAPTALS

COMPLETED FORMS SHOULD BE RETURNED TO THE SERVICE MANAGER AT THE ABOVE ADDRESS. INCOMPLETE APPLICATION AND CONSENT FORMS CANNOT BE PROCESSED.

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	

What programme are you applying for at Abode?

ATTAIN ☐ **INDEPENDENT LIVING** ☐

What do you hope to achieve from this programme?

_____

_____

Career Plan

Please use this space to describe yourself, current activities and interests.

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.

Third Level / Post Leaving Certificate/ Training Courses

College	Course	Dates	Educational awards received

Secondary Education

School	Dates	Subjects Studied	Educational awards received

Reference

Please give details of a person we may contact to give you a reference. This could be an employer or trainer who knows you.

Name	
Job Title	
Address	
Phone Number	

DISABILITY & SUPPORTS

Please give details of any physical or sensory disability, learning difficulty or health difficulty you have.

Please describe how this affects you.

Please list any supports you need, including mobility aids, assistive technology and personal assistance.

Are you taking any medication? **Yes** ☐ **No** ☐

If yes, please list medications

_____

_____

Please describe any side effects of the medication you are taking.

Who should we contact in case of emergency?

Name	
Address	
Relationship	
Home phone	
Mobile phone	

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	

You may be required to ask your doctor to complete a Medical Report before commencing training at Abode.

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

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 I have the right to restrict what information may be shared and with whom, but this may affect the provision of services to me.

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

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.

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