

Doorway to Life (Abode)

Kilbrack Grove, Skehard Road, Blackrock, Cork.

Telephone 021 4916180

PART 1 DAY SERVICE / INDEPENDENT LIVING PROGRAMME APPLICATION FORM

INCOMPLETE APPLICATION FORMS WILL NOT BE ACCEPTED
PLEASE USE BLOCK CAPTALS

Date of Application _____

Personal Details

First Name _____

Surname _____

Home Address _____

Telephone Number _____

Date of Birth _____

Height _____ Weight _____

PPS Number _____

Social Welfare Payment Type
(Disability Allowance, Disability Benefit etc.) _____

Nature of Disability

Please tick where appropriate:

Physical Disability _____ Significant Ongoing Illness _____

Visual Impairment _____ Dyslexia _____

Hearing Impairment _____ Other _____
(Please give details)

Acquired Disability _____ _____

Name and Address of Carer / Next of Kin (if applicable)

Telephone numbers (including emergencies)

Name and Address of Referral Agency (if applicable)

Telephone numbers (including emergencies)

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

Family ___ G.P. ___ Voluntary Organisation ___ Home Help ___

Public Health Nurse ___ Occupational Therapist ___ Neighbours ___

Physiotherapist ___ Personal Assistant ___ Other ___

Social Network (including family, clubs and society membership etc)

Hobbies and Interests

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 and add to the list as necessary)

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

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 Hospital and is not equipped or staffed as such. Applicants who need active medical treatment cannot be catered for at Abode. An understanding to this effect is required before admission.

In the event of a deterioration in the applicant's condition after arrival, arrangements will be made by the Carer/Next of Kin and/or Referral Agency signing this form to have the applicant transferred from Abode.

Service users are free to come and go from the Centre as they wish. However, they must inform staff of their departure and expected time of return. A person leaving the premises in this manner takes full responsibility for their own health and safety.

All special appliances required by the applicant, such as convenes, catheters, drainage bags, nappies, pads, incontinence sheets etc **MUST be supplied by the applicant upon arrival at Abode.**

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 _____ **Date** _____

Carer / Next of Kin _____ **Date** _____

Referral Agency _____ **Date** _____

PART 2 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

PART 3 MEDICATION CONSENT FORM

If you are staying in the hostel and require medication please submit a prescription at least two weeks before you are due to stay.

Your medication will be dispensed, by Abode staff, bubble packed from our local pharmacy. Any remaining medication will be given to you on departure.

Please sign below to confirm acceptance 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

PART 4 MEDICAL REPORT
(to be completed by applicant's Doctor)

Applicants Name and Address

Doctor's Name and Address

Doctors Telephone Number _____

Applicant's Medical or Drug Payments Card Number _____

Doctor's Registered Number on card _____

Medical History / Diagnosis

Date of most recent hospital stay _____

Current Medications (including times 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.

Has the applicant a history of psychiatric illness or challenging behaviour

Is the applicant allergic to any medications?
