



Application form for Carer's Allowance

The quickest and easiest way to apply for Carer's Allowance is on MyWelfare, a verified MyGovID is required.

You can go directly to the Carer's Allowance application on MyWelfare by scanning this QR code or by visiting **www.MyWelfare.ie/carersallowance**.



What is Carer's Allowance?

Carer's Allowance is a means tested payment made to people who are caring full-time for a person who has a disability or illness. The person being cared for must require full-time care and attention.

How do I qualify for Carer's Allowance?

You can qualify for Carer's Allowance if:

- you are 18 years of age or over and are providing full-time care and attention to a person who needs it and who does not normally live in an institution.
- you are not working, self-employed or on a training or education course for more than 18.5 hours a week.

How should this form be completed?

There is an example on the back of this page that can be used as a guide. Please ensure that:

- the form is completed with a **black** ballpoint pen, using capital letters and placing an **X** in the relevant boxes.
- you complete **Section 1** and **Section 2** and answer all questions that apply to you.
- **Section 3** is completed by the doctor of the person you are caring for.

How do I submit the completed form?

You should send the completed form by post to:

Carer's Allowance Section,
Department of Social Protection,
Government Buildings,
Ballinalee Road,
Longford,
N39 E4E0

How can I get help and further information?

If you need any help to complete this form, please contact us by phone at **0818 927 770** or **043 334 0000**. You can also contact your local Intreo Centre, Social Welfare Branch Office or any Citizens Information Centre. The name and address of your local Intreo Centre or Social Welfare Branch Office can be found by visiting **www.gov.ie/intreocentres**

For more information please visit **www.gov.ie/CA**

How to fill in this form

To help us process your application, write letters and numbers clearly and use one box for each. Please see examples below.

Part 1

Your details

1. PPS number:

1	2	3	4	5	6	7	T	
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2. Title, insert an **X** or specify:

	Mr	X	Mrs		Ms		Other						
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3. Surname:

M	U	R	P	H	Y											
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4. First names:

M	A	U	R	E	E	N										
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5. Birth surname:

M	O	R	A	N												
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6. Date of birth:

2	8		0	2		1	9	7	0
D	D		M	M		Y	Y	Y	Y

7. Address:

1		N	E	W		S	T	R	E	E	T								
O	L	D		T	O	W	N												
D	O	N	E	G	A	L		T	O	W	N								
County		D	O	N	E	G	A	L			Eircode		A	6	5	F	4	E	2

8. Telephone number:

0	8	8	1	2	3	4	5	6	7				
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9. Email address:

M	M	U	R	P	H	Y	@	W	E	L	F	A	R	E	.	I	E		

SAMPLE



Application form for Carer's Allowance

Part 1

Your details

1. PPS number:

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2. Title, insert an **X** or specify:

☐	Mr	☐	Mrs	☐	Ms	Other	☐	☐	☐	☐	☐	☐	☐
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3. Surname:

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4. First names:

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5. Birth surname:

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6. Date of birth:

☐	☐	☐	☐	☐	☐	☐	☐
D	D	M	M	Y	Y	Y	Y

7. Address:

County

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Eircode

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8. Telephone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

9. Email address:

10. What is your status?

☐	Single
☐	Cohabitant, married or in a civil partnership
☐	Separated, divorced or a former civil partner
☐	Widowed or a surviving civil partner

Habitual Residence Condition

The habitual residence condition means that you have a proven close link to Ireland. To satisfy the Habitual Residence Condition (HRC) you must:

- Have the right to live in the State with permission to access social welfare payments and
- Have proven close ties to Ireland where you may have lived here for a significant period and intend to stay here for the foreseeable future.

You will only be regarded as being habitually resident if you satisfy both parts of the condition. Habitual residence in Ireland is a condition that you must satisfy to qualify for this social protection payment.

11. Have you lived outside of Ireland for any period longer than three months in the last 5 years? ☐ Yes ☐ No

If **no**, proceed to **question 13**.

If **yes**, please provide the following information:

Please provide details of the countries you have lived in during the last five years, including Ireland, starting with your most recent residence:

Period 1

Country:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

From:

--	--	--	--	--	--	--	--

To:

--	--	--	--	--	--	--	--

D D

M M

Y Y Y Y

Did you have the necessary permission to reside in the country at that time? ☐ Yes ☐ No

How did you support yourself during this period of residency in this country?

--

What was the purpose of your stay in the country?

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Habitual Residence Condition

Period 2

Country:

From:

To:

D D M M Y Y Y Y

Did you have the necessary permission to reside in the country at that time? ☐ Yes ☐ No

How did you support yourself during this period of residency in this country?

What was the purpose of your stay in the country?

Period 3

Country:

From:

To:

D D M M Y Y Y Y

Did you have the necessary permission to reside in the country at that time? ☐ Yes ☐ No

How did you support yourself during this period of residency in this country?

What was the purpose of your stay in the country?

12. Have you lived in Ireland at any period not already listed?

☐ Yes☐ No

If **yes**, please provide details:

13. What date did you start your current residence in Ireland?

D D

M M

Y Y Y Y

14. Do you require an Irish Residence Permit (IRP) to work and live in Ireland?

☐ Yes☐ No

Note: An IRP is required if you are a citizen from outside an EU/EEA member state or Switzerland.
UK citizens do not require an IRP.

If **yes**, please provide the following information:

Do you have a current or valid Irish Residence Permit?

☐ Yes☐ No

Irish Residence Permit card number:

Current IRP expiry date:

D D

M M

Y Y Y Y

Note: Please provide a copy of your IRP card and IRP letter with your application.

If **no**, please provide details of your current resident status in Ireland:

15. Are you currently employed?

☐ Yes☐ No

If **yes**, please have your employer complete the **Employer Declaration (CA-ER1)** which is available to print from **www.gov.ie/CA**

16. Are you currently self-employed?

☐ Yes☐ No

If **no**, please proceed to **question 21**.

17. Please confirm the number of self-employment hours you currently work: . a week

18. What year did you submit your most recent Income Tax Return and Self-Assessment? 20
Y Y Y Y

Note: If you haven't submitted an Income Tax Return and Self-Assessment yet, please enter the current year.

19. Please confirm the number of self-employment hours you worked during the above submission year: . a week

Note: If you haven't submitted an Income Tax Return and Self-Assessment yet, please enter the number of employment hours you currently work.

20. Do you intend to leave self-employment or reduce your hours if awarded Carer's Allowance? ☐ Yes ☐ No

If **yes**, please confirm the date you will leave self-employment or reduce your hours:
D D M M Y Y Y Y

Training and Education

21. Are you currently engaged in training or education? ☐ Yes ☐ No

If **yes**, you must have the **Education Declaration (CAR-ED1)** completed by your education or training course provider. This form is available to print from www.gov.ie/CA

22. Do you intend to engage in or continue any of the following activities while in receipt of Carer's Allowance? To be eligible for Carer's Allowance, you cannot be engaged in employment, self-employment, training or education for more than 18.5 hours a week. Please mark all that apply:

☐ Employment ☐ Self-Employment
☐ Training or Education ☐ No, I will not be engaging in these activities.

If you intend to engage in employment, self-employment, training or education please confirm the number of hours you will engage in these activities if awarded Carer's Allowance: . a week

Please describe the care arrangements that will be made if you are engaging in employment, self-employment, training or education.

Child Support Payment

The Child Support Payment is an increase on your social welfare payment for any dependent children you have. This includes any dependent child you may be applying for Carer's Allowance for.

You can find out more about the Child Support Payment on www.gov.ie/csp

23. Do you have any dependent children?

☐

Yes

☐

No

Note: You must live with or contribute substantially to the maintenance or upkeep of a child aged 17 years or younger for them to be dependent. A child aged 18 and up to 22 years who is currently in full-time education may also be considered dependent.

If **yes**, please state the child's:

Child 1

Surname:

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First names:

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PPS number:

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Child 2

Surname:

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First names:

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PPS number:

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Child 3

Surname:

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First names:

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PPS number:

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Child 4

Surname:

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First names:

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PPS number:

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Note: If needed, a separate sheet of paper can be used for details of any other children you may have.

Part 4

Your partner's details

24. Partner's PPS number:

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25. Partner's title, insert an **X** or specify:

☐	Mr	☐	Mrs	☐	Ms	Other						
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26. Partner's surname:

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27. Partner's first names:

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Part 5

You and your partner's finances

Carer's Allowance is a means tested payment. You are required by law to declare all of your financial resources.

28. Do you or your partner currently receive income from any of the following?

(A) Do you or your partner currently receive income from employment, including Community Employment (CE), Tús and the Rural Social scheme?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
Please provide the name of the current employer or employment scheme:				
How much is earned per week before deductions?	€		€	
Are payments made towards a private pension? If yes , please state weekly amount:	€		€	
Is union membership paid? If yes , please state weekly amount:	€		€	
If you are a civil servant, do you pay a pension related deduction? If yes , please state weekly amount:	€		€	

(B) Do you or your partner currently receive income from self-employment?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
Describe the type of self-employment work:				
How much is earned per week before deductions?	€		€	

(C) Do you or your partner currently receive income from farming?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
How much is earned each year before any deductions?	€		€	
How much are the farm expenses each year?	€		€	
Are any payments received from agri-environmental schemes? If yes , please state total amount received each year:	€		€	
Are there any expenses associated with the agri-environmental schemes? If yes , please state the yearly total amount:	€		€	

(D) Do you or your partner currently receive income from the letting of land?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
How much is earned each year before any deductions?	€		€	

Note: Please provide a copy of the letting agreement or a letter from the tenant confirming the amount of rent being paid.

(E) Do you or your partner currently receive income from the rental of a room in the house you live in?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
How much is earned per week from renting a room in the house you live in?	€		€	

Note: Please provide a copy of the rental agreement or a letter from the tenant confirming the amount of rent being paid.

(F) Do you or your partner currently receive maintenance?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
How much maintenance is received per week, that is not paid in respect of a child?	€		€	

(G) Do you or your partner currently receive income from an Irish private pension?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
What organisation pays this pension?				

Continued on the next page.

(H) Do you or your partner currently receive income from a foreign private pension?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
What organisation pays this pension?				

For each foreign private pension you hold, please provide one of the following from your pension provider:

- A payslip showing the weekly or monthly amount you receive; **or**
- A statement showing the weekly or monthly amount you receive; **or**
- A letter showing the weekly or monthly amount you receive.

(I) Foreign Social Welfare, including state pensions, child or family state payments or welfare supports:

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
Type of social welfare payment:				

For each foreign social welfare payment you receive, please provide one of the following from the social security agency:

- A payslip showing the weekly or monthly amount you receive; **or**
- A statement showing the weekly or monthly amount you receive; **or**
- A letter showing the weekly or monthly amount you receive.

(J) Do you or your partner currently have any other investments?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
Describe the type of payment:				
Is the investment jointly owned?	☐ Yes	☐ No	☐ Yes	☐ No
What is the current value of the investment?	€		€	

(K) Do you or your partner have any shares? This includes shares in a creamery or Co-op, annuities, bonds, funds and insurance policies.

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
What is the name of the company the shares are held in?				
How many shares are held?				
Are the shares jointly owned?	☐ Yes	☐ No	☐ Yes	☐ No

Note: For each company you hold shares in, please provide a share certificate showing the number of shares held and their current market value.

(L) Do you or your partner have any property not personally occupied by you? This includes apartments, business properties, houses and vacant sites or land.

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
Address of property:				
Country:				
Current market value:	€		€	
If the property is rented, how much is earned each week from rent?	€		€	
Is the property jointly owned? If yes , please state the name of joint owner:				
What is the remaining mortgage on the property?	€		€	

Please provide a mortgage statement for each property that you own that:

- has an outstanding mortgage; **and**
- is not personally occupied by you.

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If yes , please state:			
Details of sale or transfer:				

	You		Partner	
	Yes	No	Yes	No
	If yes , please state:			
Source of income:				
What is the average weekly income from this source?	€		€	

29. Do you or your partner have any current or saving accounts, in Ireland or internationally?

If **yes**, please state:

Name of financial institution:	
International Bank Account Number (IBAN):	
Bank Identifier Code BIC:	
Current balance:	€
Is this account a joint account?	☐ Yes ☐ No
Names of account holders:	
Name 1:	
Name 2, if any:	

Financial Institution 2

Name of financial institution:

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International Bank Account
Number (IBAN):

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Bank Identifier Code BIC:

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Current balance:

€

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Is this account a joint account?

☐

Yes

☐

No

Names of account holders:

Name 1:

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Name 2, if any:

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Financial Institution 3

Name of financial institution:

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International Bank Account
Number (IBAN):

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Bank Identifier Code BIC:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Current balance:

€

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Is this account a joint account?

☐

Yes

☐

No

Names of account holders:

Name 1:

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Name 2, if any:

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Note: If you have other accounts, you must give details of them to this department on a separate sheet of paper.

Part 6

Your payment details

You can get your payment at a post office of your choice or direct to your current, deposit or savings account in a financial institution. An account must be in your name or jointly held by you.

Please complete **one** option below.

Post Office

Post office name:

Address:

CountyEircode

Note: You will need a Public Services Card (PSC) to collect your payment at a Post Office.

Financial Institution

You will find the following details printed on statements from your financial institution.

Name of financial institution:

International Bank Account Number (IBAN):

Bank Identifier Code BIC:

Names of account holders:

Name 1:

Name 2, if any:

Part 7

Details of the person you are caring for

30. Their PPS number:

31. Title, insert an **X** or specify:

☐ Mr ☐ Mrs ☐ Ms ☐ Other

32. Their surname:

33. Their first names:

34. Date of birth:

35. Are you currently caring for this person?

☐ Yes ☐ No

If **no**, when will you be caring for them?

D D M M Y Y Y Y

36. Do you share the caring responsibilities on a week on, week off basis where someone else is also a carer for the person you care for?

☐ Yes ☐ No

Note: You can share caring responsibilities with another person, where you each care for someone on a part-time basis. You must both provide care from Monday to Sunday, but on alternate weeks.

Hours of Care

To qualify for Carer's Allowance, you must be providing at least 35 hours of care over a minimum 5 days each week.

Care hours should include all aspects of caring for a person who needs full-time care and continual supervision because of age, disability, or illness including mental illness. This might include:

- help with mobility or transport,
- help with dressing, feeding, bathing,
- continence care,
- medication management.

Please be as **specific as possible** about how many hours of care you provide each day. If you don't spend time caring on any of the below days, please enter a zero (0) in the space available.

37. How many hours a day do you provide care? Insert the hours for each day.

Monday

Friday

Tuesday

Saturday

Wednesday

Sunday

Thursday

38. Do you live with the person you are caring for?

☐ Yes

☐ No

If **yes**, please proceed to **question 41**.

If **no**, please state their address:

County																				
Eircode																				

39. How far away do you live from the person you are caring for?

☐ Less than 50 kilometres.

☐ 50 to 100 kilometres.

☐ 100 to 150 kilometres.

☐ More than 150 kilometres.

40. What communication system links your household with the household of the person you are caring for?
Please place an **X** in all that apply.

☐ Landline phone.

☐ Mobile phone.

☐ Personal monitored alarm system.

☐ Other, please state:

--

41. Does the person you care for attend a care centre or other setting, such as a nursing home, rehabilitation centre or day care?

☐ Yes ☐ No

Do they stay overnight in this care centre or other setting?

☐ Yes ☐ No

If **yes**, what is the number of nights they stay each week?

nights

What is the number of days they attend each week?

days

Note: A person can be regarded as receiving full-time care and attention while attending a day care centre during the daytime. If the person stays overnight, you must state this clearly. Please attach a letter of confirmation from the care centre.

What is the name and address of the care centre or setting?

Name:

Address:

County

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Eircode

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42. Is the person you are caring for currently in hospital or a nursing home?

☐ Yes ☐ No

If **yes**, please state:

Date they were admitted to the hospital or nursing home:

D	D	M	M	Y	Y	Y	Y

Note: If the person you are caring for is in hospital or in a nursing home, you must provide a discharge letter before Carer's Allowance can be awarded.

43. Is Domiciliary Care Allowance currently in payment to you or another person if you are caring for a child under 16 years of age?

☐ Yes ☐ No

Note: If Domiciliary Care Allowance is in payment, you will not have to submit a medical report or complete **Part 10** as part of this application.

I declare that I have advised the person I care for of this application and that the information I have provided in this application is truthful and complete. If any of the information is untrue or misleading, or if I fail to disclose any relevant information, I understand that I will be required to repay any payment I receive and that I may be prosecuted. I undertake to immediately advise the department of any changes in my circumstances, or the circumstances of the person I care for, that may affect my continued entitlement.

I understand that my claim may be reviewed at any time to ensure that both the person I care for and I continue to meet the eligibility criteria.

Date:

2

0

D

D

M

M

Y

Y

Y

Y

Signature, **not** capital letters.

Warning: If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.



Section 2

Care Needs

Part 9

Carer's Details

1. PPS number:
2. Title, insert an **X** or specify: ☐ Mr ☐ Mrs ☐ Ms Other
3. Surname:
4. First names:
5. PPS number of the person you are caring for:

Part 10

Care Needs

Physical or Personal Care

6. Does the person you care for need help or assistance to eat or drink? For example, they may need supervision while eating or need to be spoon or tube fed. ☐ Yes ☐ No

If **yes**, please tell us about the help or assistance to eat or drink that they need. Please include how often you have to provide this help:

7. Does the person you care for have difficulty washing themselves without help? This might include brushing their teeth and washing their hands, face, or body. ☐ Yes ☐ No

If **yes**, please give details of the help and support they need to wash, including:

- the difficulties they experience washing themselves,
- the care you have to provide to them, and
- how often they require this care.

8. Does the person you care for have difficulty dressing themselves? This might include managing buttons and zips, or putting on socks and shoes.

☐ Yes☐ No

If **yes**, please give details of the help and support they need to dress, including:

- the difficulties they experience dressing themselves,
- the care you have to provide to them, and
- how often they require this care.

9. Does the person you care for need help using the toilet?

☐ Yes☐ No

If **yes**, please give details of the help they need when using the toilet, including how often you have to provide this support.

10. Does the person you care for have continence problems such as wetting or soiling?

☐ Yes☐ No

If **yes**, please give details of the help and support they need, including:

- how often they have problems with wetting or soiling, and
- the care you have to provide to them.

11. Does the person you care for have hearing or vision difficulties?

☐ Yes

☐ No

If **yes**, please give details of their hearing or vision difficulties, including:

- the care they need, and
- any specialist equipment or assistive technologies used.

12. Does the person you care for have difficulty walking or moving around?

☐ Yes

☐ No

If **yes**, which of the following describe their difficulties? Please place an **X** in all that apply:

- ☐ Needs help moving to or from a bed or chair.
- ☐ Needs help moving to or from a toilet, bath or shower.
- ☐ Needs a walking stick or mobility aid to get around the house.
- ☐ Needs help climbing up and down stairs.
- ☐ None of the above.

Please tell us more about their difficulties walking or moving around, including:

- the care they need,
- how often you have to provide this care, and
- any specialist equipment or mobility aids used.

13. Does the person you care for often require care during the night? For example, they may need supervision and help with toileting, medication, or pain relief.

☐ Yes

☐ No

If **yes**, please give details of the care they need at night, including how often you have to provide this care.

Learning, Behaviour, Memory or Mental Health

14. Does the person you care for experience challenges communicating with other people? This might include speech and language difficulties or difficulty expressing their needs.

☐ Yes☐ No

If **yes**, please give details of the help and support they need, including:

- the challenges they experience communicating,
- the care you have to provide to them, and
- how often they require this care.

15. Does the person you care for have a learning or behavioural disability that affects them day-to-day?

☐ Yes☐ No

If **yes**, please give details of their disability, including:

- how it affects their understanding of day-to-day activities,
- how it affects their ability to complete day-to-day activities, and
- the care you have to provide to support them.

16. Does the person you care for have a mental health condition?

☐ Yes

☐ No

If **yes**, please give details of their condition, including:

- how it impacts them, and
- the care you provide to support them.

17. Does the person you care for experience memory loss or have dementia?

☐ Yes

☐ No

If **yes**, please give details of how memory loss or dementia impacts them and the care you have to provide to support them.

18. Does the person you care for experience loss of consciousness? For example, fainting episodes, blackouts, or seizures.

☐ Yes

☐ No

If **yes**, please give details of the difficulties they experience with loss of consciousness, including:

- how it impacts them,
- how often they've experienced loss of consciousness in the last 12 months, and
- the care you provide for them.

Additional supervision and care needs might include:

- the use of specialist equipment,
- techniques to help with breathing,
- special feeding arrangements,
- dialysis,
- dressing wounds,
- stoma care requirements,
- special transport arrangements, and
- preparation and administration of medication.

19. Does the person you care for have any additional care needs that have not already been mentioned in this application?

☐

Yes

☐

No

If **yes**, please give details of their additional care needs, including:

- how often they occur,
- any care you provide to help, and
- any specialist equipment or arrangements required.

20. Is there anything else you would like to tell us about the condition or care needs of the person you care for?

☐

Yes

☐

No

If **yes**, please tell us about any other concerns you have regarding their condition or care needs.

Data Protection Statement

The Department of Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments and benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at www.gov.ie/dsp/privacystatement or in hard copy.

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Medical Report for Carer's Allowance

Part 1

Carer's details

1. PPS number:

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2. Title, insert an **X** or specify:

☐	Mr	☐	Mrs	☐	Ms	Other	☐	☐	☐	☐	☐	☐
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3. Surname:

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4. First names:

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5. Date of birth:

D	D	M	M	Y	Y	Y	Y		

Part 2

Medical Report

Dear Doctor,

To enable us to accurately assess the level of care and attention your patient requires, please complete the medical report below. The medical information provided will be reviewed by our medical assessors and will be treated in strictest confidence. Although a confidential report, both medical and non-medical staff will need to deal with this report in order to process the claim.

You will be paid a special fee for fully completing and returning this report. To ensure payment, please enter your DSP Panel Number in the box provided.

For reasons of medical confidentiality, without potential inspection by a third party, you may wish to send the medical report to the department's Chief Medical Advisor. If you have any questions on this matter, please contact the Carer's Scheme section on **043 334 0000** or **0818 927 770**, or **+353 43 334 0000** if calling from outside of Ireland.

Medical Report begins on the next page.

6. Patient's details:

Surname:

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First names:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address:

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County

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Eircode

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Date of birth:

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D D M M Y Y Y Y

PPS number:

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Your patient since:

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D D M M Y Y Y Y

Main diagnosis or diagnoses:

Diagnosis relevant to application	Date (MM/YY) of diagnosis, if relevant	ICD10 code

Current medications:

Medication relevant to application	Dose	Medication, if relevant	Dose, if relevant
1.		5.	
2.		6.	
3.		7.	
4.		8.	

7. Is your patient terminally ill?

☐

Yes

☐

No

8. Please give details of the following:

Relevant hospital admissions and attending specialists including recent or relevant dates and approximate duration:

Note: Please attach any relevant reports, staging and results of investigations, if available.

Other information, if relevant:

9. Please describe your patient's care needs under the following headings:

Cognition:

☐

Normal

☐

Impaired

Dementia:

☐

Yes

☐

No

General learning disability:

☐

Yes

☐

No

If **yes** to either of the above, please state level of care provided:

Results of MMSE, FSIQ, MOCA or equivalent if available:

Mental Health:☐

Normal

☐

Impaired

Please state the level of care and support provided and any specific concerns:

Seizures:☐

Stable

☐

Unstable

If **unstable**, state frequency:**Does the patient have epilepsy?**☐

Yes

☐

No

If **yes**, please state what type:**Mobility:**☐

Dependent

☐

Independent or age-appropriate

Please describe the care that is required, for example, needs assistance, walking aids, immobility, or wheelchair dependency:

10. Please indicate the degree to which your patient's faculties have been affected and the level of care provided in the following, if known:

Area	Ability level			
	Normal	Glasses or hearing aids	Impaired	If impaired, please describe known care needs
Vision				
Hearing				
Speech				

Area	Ability level			
	Independent	Dependent	Do not know	If dependent, please describe known care needs
Continence or toileting				
Bathing or showering				
Feeding				
Dressing				

Specific conditions:

How long do you expect these care needs to continue?

☐ Less than 12 months.
 ☐ 12 to 24 months.
 ☐ Unknown.
 ☐ Indefinitely.

Current clinical findings, care needs or concerns:

11. GP's name:

12. DSP panel number:

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13. IMC number:

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14. Address:

County

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Eircode

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Doctor's signature, **not** capital letters.

Date:

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D D

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Y Y Y Y

Doctor's official stamp

All information given in this section is covered by the Data Protection Act and the Official Secrets Act.

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