Toronto Acquired Brain Injury Network

Please include any relevant medical documentation or clinical notes to support this referral. Some programs will be unable to process the referral without confirmation of the brain injury.

ABI CLIENT *Community* PROFILE

FAX COMPLETED APPLICATION TO: (416) 597-7021

Client's Name: ______________________ (surname) ______________________ (given name(s)) ☐ male ☐ female

Health Card #: ______________________ **Version:** _____ (if any) **Date of Birth:** _____ / _____ / _____ (year / month / day)

Date of Injury/Event: _______ / _______ / _______ (year / month / day)

Was this injury/event work-related? ☐ yes

Nature/Type of Injury/Event: ☐ mvc ☐ mvc *(motorcycle)* ☐ mvc *(on bicycle/pedestrian)* ☐ fall ☐ assault ☐ sporting ☐ unknown
☐ trauma-other *(specify)* ______________________
☐ non-trauma *(specify)* ______________________

Referral Destination:

☐ Day Hospital *(please circle site)*: (a) Toronto Rehab - University Centre; (b) Toronto Rehab – Rumsey Centre; (c) Bridgepoint Health; (d) Holland Bloorview Kids Rehabilitation Hospital

☐ West Park Outpatient Clinic ☐ West Park ABI Adult Day Program ☐ CHIRS ☐ Head Injury Clinic

☐ Holland Bloorview Kids Rehabilitation Hospital: Family Support Service

☐ COTA Health ABI case management ☐ COTA Health Adult Day Service ☐ COTA Health Supportive Housing (Collegeview)

☐ CCAC ABI Program (*specify service requested, e.g. OT,PT)*: ______________________

Referral Source: Contact name/position: ______________________ Phone: ( ) ______________
Organization: ______________________ Pager: ( ) ______________

Client is Currently: ☐ at home ☐ other (specify): ______________________

If client in hospital, please provide:

Date of Admission: _____ / _____ / _____ (year / month / day) **Planned Date of Discharge**: _____ / _____ / _____ (year / month / day)

Home Address: ______________________

____

______________ Postal Code: ______________

Telephone: ( ) ______________________

Home Living Situation:

☐ alone ☐ with others *(specify)* ______________

Accommodation:

☐ house ☐ apartment building ☐ supportive housing

☐ rooming house ☐ other ______________

Referring Physician: ______________________

Address: ______________________

Telephone: ( ) ______________________

Signature: ______________________

Billing # ______________________

Family Physician: ______________________

Address: ______________________

Postal Code: ______________________

Telephone: ( ) ______________________

Billing #: ______________________

Urgent Issues: ______________________

____

REASON FOR REFERRAL:

CLIENT/FAMILY	REFERRAL SOURCE

This page submitted by: ______________ (print name) ______________ (signature) _____ / _____ / _____ (year / month / day)

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SERVICE INFORMATION

(ABI Client *Community* Profile)

Name: ____

TREATMENT HISTORY INCLUDING CURRENT SERVICES

Program/Facility	Dates Involved (year/month/day)	Contact Name and Number

Current Therapy Staff Involved:

Contact Name	Discipline	Telephone

Follow Up Appointments Booked: ☐ yes ☐ no

Dates (year/month/day):	Purpose/specialty:	With whom:	Telephone number:
_______/ _______/ _______	__________________________	__________________________	( ) __________________
_______/ _______/ _______	__________________________	__________________________	( ) __________________
_______/ _______/ _______	__________________________	__________________________	( ) __________________

Neuropsychological Assessments Completed: ☐ yes ☐ no

Date completed: _____/ _____/ _______ By whom: _________________________ Phone #: ( ) _________________

year month day

TRANSPORTATION:

Mode of transportation for attending program/service: ☐ Independent ☐ Assisted ☐ Other

Wheel Trans applied for: ☐ yes ☐ no **Wheel Trans #:** ____

Has the Ministry of Transportation been informed of the injury? ☐ no ☐ yes By whom? __________________________

Languages spoken: ____

Interpreter required: ☐ yes Name of Interpreter:_______________________ Relationship to Client: _____________________

☐ no Home Phone #: ( ) __________________ Work Phone #: ( ) ___________________

Access to paid interpreter: ☐ yes ☐ no Contact: ____

This page submitted by: ______________________________ ________________________________ _______ / _______ / _______

print name *signature* *date (yy/mm/dd)*

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SOCIAL INFORMATION

(ABI Client *Community* Profile)

Name: ______________________________

Substitute Decision-Maker: ______________________________

Address: ______________________________

______________________ Postal Code: ______________________

Phone: Home: ( ) ______________ Work: ( ) ______________

Relationship to Client:

- ☐ spouse/partner
- ☐ parent ☐ sibling
- ☐ daughter ☐ son
- ☐ other ______________ *specify*

Contact Person: *if different from substitute decision-maker*

Name: ______________________________

Phone: ( ) ______________ Relationship: ______________________

EDUCATION:

Highest grade/level attained: ______ **If in school, name of school:** ______________________

Employed at time of injury/event: ☐ yes ☐ no Type and duration of employment: ______________________

____

FAMILY/SUPPORT NETWORK INFORMATION *(Please attach Social Work Assessment if available)*

Relevant considerations: ______________________________

____

FINANCIAL INFORMATION:

Source:	Status (initiated, date submitted, approved):
☐ WSIB	______________________________
☐ CPP	______________________________
☐ Auto Insurance	______________________________
☐ Ontario Works	______________________________
☐ ODSP	______________________________
☐ EI	______________________________
☐ OAS	______________________________
☐ STD	______________________________
☐ LTD	______________________________
☐ Other	______________________________

Professionals/Agencies currently involved:

Adjuster/Adjudicator:	Company:______________	Contact: ______________	Phone: ( ) ______________
Case Manager:	Company:______________	Contact: ______________	Phone: ( ) ______________
Lawyer:	Firm:______________	Contact: ______________	Phone: ( ) ______________
Other:	Company:______________	Contact: ______________	Phone: ( ) ______________

This page submitted by: ______________________ ______________________ ______ / ______ / ______

print name *signature* *date (yy/mm/dd)*

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MEDICAL INFORMATION

(ABI Client *Community* Profile)

Name: ______________________________

Diagnosis: ______________________________

____

____

Seizures: ☐ yes ☐ no Dates: ____________ Describe: ____________

Loss of Consciousness: ☐ yes ☐ no **Coma Length:** ____________

Post Traumatic Amnesia: ☐ yes ☐ no Duration: ____________

CT/MRI Results: ______________________________

Date of Completion: _____ / _____ / _____ (*year* / *month* / *day*) **Facility:** ____________

Past & relevant medical history: ______________________________

____

Previous history of ABI: ☐ yes ☐ no Describe**:** ____________

Pre-Injury History of Substance Abuse: ☐ yes ☐ no ☐ history not available **Status on admission:** ____________

Current Substance Abuse: ☐ yes ☐ no ☐ not known **Substance Abuse Treatment Recommended:** ☐ yes ☐ no

Previous psychiatric history: ☐ yes ☐ no Describe: ____________

Current psychiatric status: ______________________________

Psychiatric consult notes: ☐ included ☐ report to follow ☐ not available

Current treatment providers: ______________________________

Is individual on antibiotics: ☐ yes ☐ no If yes, why: ____________

Does individual have:

MRSA:	☐ yes	☐ no	☐ unknown
VRE:	☐ yes	☐ no	☐ unknown
TB:	☐ yes	☐ no	☐ unknown
C-Difficile:	☐ yes	☐ no	☐ unknown

Is individual in isolation: ☐ yes ☐ no If yes, why: ____________

Current Medication (or attach record):

____

____

____

____

Allergies: ______________________________

____

MEDICAL STAFF INVOLVED:

PHYSICIAN	SPECIALTY	TELEPHONE NUMBER
____________	____________	( ) ____________
____________	____________	( ) ____________
____________	____________	( ) ____________

This page submitted by: ____________ (*print name*) ____________ (*signature*) ____ / ____ / ____ (*date (yy/mm/dd)*)

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FUNCTIONAL INFORMATION

(ABI Client *Community* Profile)

Name: ______________________________

BASIC PERSONAL ISSUES:

	NON-ISSUE	ISSUE
Eating/drinking:	☐	☐
Dressing:	☐	☐
Bathing:	☐	☐
Toileting *(including continence):*	☐	☐
Grooming:	☐	☐
Paresis/paralysis:	☐	☐
Medication management:	☐	☐
Pain/headaches:	☐	☐
Fatigue:	☐	☐
Sleep disturbances:	☐	☐

Identified risk(s): ______________________________

Comments:

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
(please initial)

MOBILITY:

	NON-ISSUE	ISSUE
Walking:	☐	☐
Wheelchair:	☐	☐
Transfers:	☐	☐
Outdoor mobility:	☐	☐
Falls/history of falls:	☐	☐
Stamina:	☐	☐
Balance/dizziness:	☐	☐

Identified risk(s): ______________________________

Comments:

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
(please initial)

INSTRUMENTAL NEEDS:

	NON-ISSUE	ISSUE
Meal preparation:	☐	☐
Housekeeping:	☐	☐
Shopping:	☐	☐
Financial management:	☐	☐

Identified risk(s): ______________________________

Comments:

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
(please initial)

BEHAVIOUR ISSUES:

	NON-ISSUE	ISSUE
Ability to adjust to change:	☐	☐
Impulse control:	☐	☐
Mood disorder:	☐	☐
Thought disorder:	☐	☐
Wandering:	☐	☐
Aggressiveness:	☐	☐
Sexually inappropriate:	☐	☐
Suicidal risk:	☐	☐

Identified risk(s): ______________________________

Comments:

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
(please initial)

COMMUNICATION:

	NON-ISSUE	ISSUE
Hearing:	☐	☐
Vision:	☐	☐
Language, comprehension:	☐	☐
Language, expression:	☐	☐
Pragmatics/conversational skills:	☐	☐
Swallowing:	☐	☐ *(specify diet, food texture)*

Identified risk(s): ______________________________

Comments:

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
(please initial)

COGNITIVE STATUS:

	NOT TESTED	INTACT	IMPAIRED
Orientation:	☐	☐	☐
Motivation/initiation:	☐	☐	☐
Judgement:	☐	☐	☐
Memory (short term):	☐	☐	☐
Memory (long term):	☐	☐	☐
Attention:	☐	☐	☐
Follow instructions:	☐	☐	☐
Frustration tolerance:	☐	☐	☐
Insight:	☐	☐	☐
Perception:	☐	☐	☐

Identified risk(s): ______________________________

Comments:

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
(please initial)

This page submitted by: ____________________ ____________________ ______ / ______ / ______

print name *signature* *date (yy/mm/dd)*

Toronto Acquired Brain Injury Network

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PERSONAL HEALTH INFORMATION

I hereby authorize ____
name of facility/agency releasing information

to release personal health information in my medical/clinical records and the *ABI Client Community Profile* / *ABI Service Referral Form for Physicians* / *Internal Transfer Report* form(s) of

____
name of patient /client

to: Toronto Acquired Brain Injury Network and

____
names of institution(s)/agency(s) requesting information

____

____

I understand that this information is to be used by the recipient(s) for the purpose of facilitating a referral; for aggregate data reporting and potentially, for research*.

Expiration Date of Authorization: ____/____/____
year month day

____
print name

____ Date: ____/____/____
signature *year month day*

Relationship if signed by other than the patient/client: ______________________________

Witness: ______________________________
print name

______________________________ Date: ____/____/____
signature *year month day*

**Summaries of this information may be used to identify trends in use of health services and to help answer research questions about brain injury and the course of treatment. No identifying information will be released other than what is needed for placement purposes as specified above.*

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