

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: _____ male female
surname given name(s)

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

Date of Injury/Event: ____/____/____ **Was this injury/event work-related?** yes
year month day

Nature/Type of Injury/Event: MVC MVC (motorcycle) MVC (on bicycle/pedestrian) fall assault sporting
 trauma-other (specify) _____ unknown
 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 (Collegievew)
 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: ____/____/____ **Planned Date of Discharge:** ____/____/____
year month day year month day

<p>Home Address: _____ _____ Postal Code: _____ Telephone: () _____</p>	<p>Home Living Situation: <input type="checkbox"/> alone <input type="checkbox"/> with others (specify) _____</p> <p>Accommodation: <input type="checkbox"/> house <input type="checkbox"/> apartment building <input type="checkbox"/> supportive housing <input type="checkbox"/> rooming house <input type="checkbox"/> other _____</p>
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<p>Referring Physician: _____ Address: _____ Telephone: () _____ Signature: _____ Billing # _____</p>	<p>Family Physician: _____ Address: _____ Postal Code: _____ Telephone: () _____ Billing #: _____</p>
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Urgent Issues: _____

REASON FOR REFERRAL:	
CLIENT/FAMILY	REFERRAL SOURCE

This page submitted by: _____ print name signature _____ year month day

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: ____/____/____
year month day By whom: _____ Phone #: () _____

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)

SOCIAL INFORMATION

(ABI Client Community Profile)

Name: _____

Substitute Decision-Maker: _____	Relationship to Client:
Address: _____	<input type="checkbox"/> spouse/partner
_____ Postal Code: _____	<input type="checkbox"/> parent <input type="checkbox"/> sibling
Phone: Home: () _____ Work: () _____	<input type="checkbox"/> daughter <input type="checkbox"/> son
	<input type="checkbox"/> other _____ <small>specify</small>
Contact Person: Name: _____	
<i>if different from substitute decision-maker</i> 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):
<input type="checkbox"/> WSIB	_____
<input type="checkbox"/> CPP	_____
<input type="checkbox"/> Auto Insurance	_____
<input type="checkbox"/> Ontario Works	_____
<input type="checkbox"/> ODSP	_____
<input type="checkbox"/> EI	_____
<input type="checkbox"/> OAS	_____
<input type="checkbox"/> STD	_____
<input type="checkbox"/> LTD	_____
<input type="checkbox"/> 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)

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: _____ / _____ / _____ Facility: _____
year month day

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:	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
VRE:	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
TB:	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
C-Difficile:	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown

Is individual in isolation: yes no If yes, why: _____

Current Medication (or attach record):

Allergies: _____

MEDICAL STAFF INVOLVED:		
PHYSICIAN	SPECIALTY	TELEPHONE NUMBER
_____	_____	() _____
_____	_____	() _____
_____	_____	() _____

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print name signature date (yy/mm/dd)

FUNCTIONAL INFORMATION

(ABI Client Community Profile)

Name: _____

BASIC PERSONAL ISSUES:	NON-ISSUE	ISSUE	Comments:
Eating/drinking:	<input type="checkbox"/>	<input type="checkbox"/>	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP (please initial)
Dressing:	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing:	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting (including continence):	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming:	<input type="checkbox"/>	<input type="checkbox"/>	
Paresis/paralysis:	<input type="checkbox"/>	<input type="checkbox"/>	
Medication management:	<input type="checkbox"/>	<input type="checkbox"/>	
Pain/headaches:	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue:	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep disturbances:	<input type="checkbox"/>	<input type="checkbox"/>	
Identified risk(s):	_____		

MOBILITY:	NON-ISSUE	ISSUE	Comments:
Walking:	<input type="checkbox"/>	<input type="checkbox"/>	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP (please initial)
Wheelchair:	<input type="checkbox"/>	<input type="checkbox"/>	
Transfers:	<input type="checkbox"/>	<input type="checkbox"/>	
Outdoor mobility:	<input type="checkbox"/>	<input type="checkbox"/>	
Falls/history of falls:	<input type="checkbox"/>	<input type="checkbox"/>	
Stamina:	<input type="checkbox"/>	<input type="checkbox"/>	
Balance/dizziness:	<input type="checkbox"/>	<input type="checkbox"/>	
Identified risk(s):	_____		

INSTRUMENTAL NEEDS:	NON-ISSUE	ISSUE	Comments:
Meal preparation:	<input type="checkbox"/>	<input type="checkbox"/>	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP (please initial)
Housekeeping:	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping:	<input type="checkbox"/>	<input type="checkbox"/>	
Financial management:	<input type="checkbox"/>	<input type="checkbox"/>	
Identified risk(s):	_____		

BEHAVIOUR ISSUES:	NON-ISSUE	ISSUE	Comments:
Ability to adjust to change:	<input type="checkbox"/>	<input type="checkbox"/>	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP (please initial)
Impulse control:	<input type="checkbox"/>	<input type="checkbox"/>	
Mood disorder:	<input type="checkbox"/>	<input type="checkbox"/>	
Thought disorder:	<input type="checkbox"/>	<input type="checkbox"/>	
Wandering:	<input type="checkbox"/>	<input type="checkbox"/>	
Aggressiveness:	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually inappropriate:	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal risk:	<input type="checkbox"/>	<input type="checkbox"/>	
Identified risk(s):	_____		

COMMUNICATION:	NON-ISSUE	ISSUE	Comments:
Hearing:	<input type="checkbox"/>	<input type="checkbox"/>	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP (please initial)
Vision:	<input type="checkbox"/>	<input type="checkbox"/>	
Language, comprehension:	<input type="checkbox"/>	<input type="checkbox"/>	
Language, expression:	<input type="checkbox"/>	<input type="checkbox"/>	
Pragmatics/conversational skills:	<input type="checkbox"/>	<input type="checkbox"/>	
Swallowing:	<input type="checkbox"/>	<input type="checkbox"/> (specify diet, food texture)	
Identified risk(s):	_____		

COGNITIVE STATUS:	NOT TESTED	INTACT	IMPAIRED	Comments:
Orientation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP (please initial)
Motivation/initiation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Judgement:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory (short term):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory (long term):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attention:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follow instructions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frustration tolerance:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insight:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Perception:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Identified risk(s):	_____			

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