

ABI CLIENT PROFILE

- Internal Transfer Report*
 Admission Notification

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

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

Service Requested:
 Day Hospital / Outpatient (specify facility/site): _____
 If day hospital/outpatient requested, select service(s) requested: PT OT SLP SW Psychology Other
 Follow-up Clinic CCAC ABI Program CHIRS _____ COTA Health _____

Home Address: _____

 Postal Code: _____ Telephone: () _____
 Alternate Contact Person/Number: _____

Referring Physician: _____ Address: _____ Telephone: () _____ Signature: _____ Billing #: _____	Family Physician: _____ Address: _____ Postal Code: _____ Telephone: () _____ Billing #: _____
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Current Therapists:

Contact Name	Discipline	Phone

Has an ABI Network Client Profile previously been submitted: Yes No Unknown

Date of Admission to New Program/Service: _____ / _____ / _____ year month day

This page completed by: _____ print name _____ signature _____ / _____ / _____ year month day

**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

signature

Date: _____
year / month / day

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

Witness: _____
print name

signature

Date: _____
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.*