Toronto abi Network

# ABI Community Referral Form

The following information **must be included** (as indicated) to avoid any delays in processing your referral:

- ❑ Patient's Address, Phone Number and E-mail
- ❑ Patient's Health Card Number
- ❑ Diagnosis
- ❑ Date of Injury/Event
- ❑ Primary reason for referral
- ❑ Referral Destination (***only publicly funded services/programs are listed***) †
- ❑ Physician's Signature and Physician's Billing Number (*only if requesting Clinic or Outpatient Rehab services*)
- ❑ ***IMPORTANT* the following medical and rehab documentation** is required:
  - ❒ Medical notes
  - ❒ Consult reports
  - ❒ Initial and most recent MRI Scans, CT Scans, and/or imaging reports related to the brain injury
  - ❒ Neuropsychological Assessment Report (*if completed*)
  - ❒ Psychiatric consult notes or mental health reports (*if completed*)

- ❑ Client has been informed that they are responsible for arranging their own transportation to and from the programs and services requested.
- ❑ Client consented to the submission of this referral.

## FAX TO: 416-597-7021

***CONCUSSION referrals:***

Due to the high volume of referrals requesting services for concussion, response times are long. The Toronto ABI Network will contact you directly if additional information is required or to provide alternatives for services. Service providers will contact the patient directly to coordinate services if accepted.

Only the following publicly funded services listed below accept concussion referrals:

- ❑ Case Management – Cota (1 year post injury)
- ❑ Physiatry – Toronto Rehab, University Health Network (< 1 year post injury)
- ❑ Psychiatry – St. Michael's Hospital, Unity Health Toronto (ONLY if within catchment area: south of Bloor/Danforth to Lake Ontario and east of Yonge St. to West of Victoria Park Ave.)

† *If you have any questions, please contact us at 416-597-3057*

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**MUST include all relevant brain injury medical and consult reports**
**(i.e., initial and most recent imaging Reports, Emergency Room Records and/or Hospital Admission/Discharge Notes).**
***The referral will be returned if the above is not included.***

# ABI *Community Referral Form*

**FAX TO: (416) 597-7021**

**Client's E-mail:** ____________________________________________

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

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

**Diagnosis:** ________________________________________________________________ ☐ Concussion/mTBI

**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 ☐ unknown
☐ trauma-other *(specify)* ______________________________________________
☐ non-trauma *(specify)* ______________________________________________

**Primary Reason for Referral /Goal(s):** ______________________________________________

**Number of visits since most recent head injury:** to Emergency Department __________ *Specify ED Site*:____________________
to Family Doctor ________________

**Referral Destination:** *For more details on the publicly-funded programs below, click on the respective link.*

***CLINICS*** **Head Injury Clinics:** ❒ Toronto Rehab/UHN Physiatry Clinic (< 1 year post injury) ❒ Sunnybrook (< 3 mths post injury, complicated mild to mod TBI with positive findings on brain imaging or GCS≤14 or facial/skull/cervical fracture)

**Neuropsychiatry Consultation:** ❒ Toronto Rehab/UHN ❒ St. Michael's Hospital (ONLY if within catchment area: south of Bloor/Danforth to Lake Ontario and east of Yonge St. to West of Victoria Park Ave.)

**Neuropsychology Assessment Clinic** ❒ (CHIRS) (> 1 yr post injury, ONLY if in Toronto Central or Central LHIN)

***OUTPATIENT REHAB*** ❒ Bridgepoint/Sinai Health System (< 1 yr post injury; includes Physiatry consultation)

❒ Toronto Rehab/UHN (< 2 yrs post injury, require 2 services, must have evidence on CT/MRI)

Sites: ❒Rumsey (Bayview & Eglinton) or ❒University Centre (University & Dundas)

***COMMUNITY***

Central LHIN Home & Community Care ❒ABI programs (< 5 years post injury)

CHIRS ❒Adult Day Services ❒Community Support Services ❒Residential Services ❒Substance Abuse and Brain Injury (SUBI) ❒Clinical Groups

Cota ❒ABI Case Management ❒Adult Day Service (Providence) ❒ Behaviour Therapy (< 5 years post injury, only in TC LHIN)

March of Dimes Canada (MODC) ❒Supportive Housing ❒ABI Community Outreach ❒Aphasia Day Program ❒Peer Group

PACE Independent Living ❒Adult Day Services ❒Supportive Housing ❒ABI Community Program

West Park Healthcare Centre ❒Behavioural Outreach ❒ABI Adult Day Program

York Simcoe Brain Injury Services (Mackenzie Health/MODC) ❒Behavioural Consultant ❒Case Manager ❒Rehab Worker ❒Adult Day Program

***OTHER:*** For referrals to Holland Bloorview Kids Rehabilitation, please submit directly to the organization.

**Home Address:** ______________________________
______________________________________________
City:________________________ Postal Code: ____________
Primary Tel Number: ( ) ________________________
Alternate Tel Number: ( )________________________

**Home Living Situation:**
☐ alone ☐ with others *(specify)* ____________________

**Accommodation:** ☐ homeless ☐ at risk of homelessness
☐ house ☐ apartment building ☐ supportive house
☐ board & care ☐ other ______________________________

**Alternate contact person & phone number:** ________________
______________________________________________

**Relationship to Patient:** SDM ☐ POA ☐ Spouse ☐

Other:______________________________________________

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker. Revised June 2019.

Client's Name: ___________________________

| **Referring Physician:** ___________________________________<br>*(Most responsible physician only, do not include Medical Residents)*<br>Address: _____________________________________________<br>City:______________________ Postal Code: _______________<br>Tel: ( ) _____________________________<br>Fax: ( ) ____________________________<br>Signature* : __________________________________________<br>Billing # *____________________________________________<br>** Required for Clinics and Outpatient Rehab services only* | **Family Physician:** ___________________________________<br>Address: _____________________________________________<br>City:______________________ Postal Code: _______________<br>Tel: ( ) ___________________<br>Billing #: ______________________________________________ |
|---|---|

**Referral Source:** Contact name/position: __________________________________ Phone: ( ) ____________________
Organization: __________________________________________ Pager/E-mail: _________________________

**Client is Currently:** ☐ at home ☐ other (specify): ____________________________________________________________________

*If client in hospital, please provide:* **Date of Admission:**___________________ **Planned Date of Discharge**:_________________

## MEDICAL INFORMATION

**Previous & 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:** ____________________________________________________________________________________

**Allergies:**

**Is individual on antibiotics?** ☐ yes ☐ no If yes, why: ____________________________________________________

**Does individual have:** ☐ MRSA ☐ VRE ☐ TB ☐ C-Difficile ☐ Other:________________________________________

**Seizures:** ☐ yes ☐ no Dates**:** ______________________ Describe: _______________________________

## SERVICE INFORMATION ❒ CONSULT NOTES ATTACHED

| **TREATMENT HISTORY INCLUDING CURRENT SERVICES** | | |
|---|---|---|
| Program/Facility/Physician/Therapies | Dates Involved (year/month/day) | Contact Name and Number |
| | | |
| | | |
| | | |

**TRANSPORTATION:** (*Please note: For most programs there are no transportation resources available*)

**Client will be travelling:** ☐ Independently ☐ With Assistance

**Wheel-Trans:** ☐ yes ☐ no **Wheel-Trans #:** ________________________ **YRT Mobility Plus:** ☐ yes ☐ no

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

**Languages Spoken:** Interpreter required: ☐ yes ☐ no

## SOCIAL INFORMATION

**FINANCIAL INFORMATION:**

**Source:**
☐ WSIB ☐ CPP ☐ Auto Insurance ☐ Ontario Works ☐ ODSP ☐ EI ☐ OAS ☐ STD ☐ LTD
☐ Other ________________________________________

**Status (***initiated, date submitted, approved***):** ____________________________________________________________________

Client's Name: ___________________________

**Previous or Current Involvement with the Justice System?** ☐ yes ☐ no

Details: ____________________________________________________________________________________________

## FUNCTIONAL INFORMATION

**Where possible, please indicate the level of assistance needed in a day: (e.g. *2 hours for bathing, toileting & grooming*)**

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

***Comments or Other Issues:***

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

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

***Comments or Other Issues:***

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

| ***INSTRUMENTAL NEEDS:*** | NON-ISSUE | ISSUE |
|---|---|---|
| Meal preparation: | ☐ | ☐ |
| Housekeeping: | ☐ | ☐ |
| Shopping: | ☐ | ☐ |
| Financial management: | ☐ | ☐ |

***Comments or Other Issues:***

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

| ***BEHAVIOUR ISSUES:*** | NON-ISSUE | ISSUE |
|---|---|---|
| Ability to adjust to change: | ☐ | ☐ |
| Impulse control: | ☐ | ☐ |
| Mood disorder: | ☐ | ☐ |
| Thought disorder: | ☐ | ☐ |
| Wandering: | ☐ | ☐ |
| Aggressiveness: | ☐ | ☐ |
| Sexually inappropriate: | ☐ | ☐ |
| Suicidal risk: | ☐ | ☐ |
| Agitation: | ☐ | ☐ |
| Easily Angered: | ☐ | ☐ |
| Frustration Tolerance: | ☐ | ☐ |

***Comments or Other Issues:***

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

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

***Comments or Other Issues:***

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

| ***COGNITIVE STATUS:*** | NOT TESTED | INTACT | IMPAIRED |
|---|---|---|---|
| Orientation: | ☐ | ☐ | ☐ |
| Motivation/initiation: | ☐ | ☐ | ☐ |
| Judgement: | ☐ | ☐ | ☐ |
| Memory (short term): | ☐ | ☐ | ☐ |
| Memory (long term): | ☐ | ☐ | ☐ |
| Attention: | ☐ | ☐ | ☐ |
| Follow instructions: | ☐ | ☐ | ☐ |
| Insight: | ☐ | ☐ | ☐ |
| Perception: | ☐ | ☐ | ☐ |

***Comments or Other Issues:***

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

This referral was completed by (*name*) ______________________________ on (*date*) ____________________

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