ABI Physician Referral - Checklist

To process this referral and avoid any delays, the following information **must be included:**

- Patient’s Address
- Patient’s Health Card Number
- Date of Injury/Event
- Referral Destination
- Physician’s Signature
- Physician’s Billing Number
- Diagnosis
- Primary Reason for referral
- Authorization Consent form: please have your patient sign the included ‘Authorization for Release of Confidential Personal Health Information’

**IMPORTANT** Medical and rehab documentation is required with this referral. Please include medical notes, consult reports, MRI Scans, CT Scans, and/or imaging reports related to the brain injury.

Please note the following admission criteria:
- St. Michael’s Head Injury Clinic – Up to 1 year post-injury
- Sunnybrook Head Injury Clinic – Up to 3 months post-injury

**Did you know?**


If you have any questions, please contact the Toronto ABI Network at 416-597-3057.
Please ensure entire form is completed and includes all relevant medical and consult reports. This referral will not be processed until all documentation related to the brain injury is received (e.g., imaging reports, emergency room records and/or hospital discharge notes).

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

Health Card #: ________________________________  Version:  _______  Date of Birth: _______ / _______ / _______

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
☐ trauma-other (specify)  ☐ unknown
☐ non-trauma (specify)  __________________________________________________________

Referral Destination:
☐ Head Injury Clinic (specify site if appropriate): ______________________________________
☐ CCAC ABI Program (specify service requested, e.g. OT, PT): ________________________________
☐ COTA Health ABI case management
☐ SMH Medical Psychiatry Clinic

Please note: the following programs also provide ABI services in Toronto. For referral information contact 416-597-3057

• Toronto Rehab Day Hospital (University site)
• Toronto Rehab Day Hospital (Rumsey site)
• CHIRS
• Bridgepoint Health Day Treatment Program
• West Park Outpatient Clinic
• West Park Behavioural Outreach

Referring Physician: ________________________________  Family Physician: ________________________________
Address: ____________________________________________  Address: ________________________________
Telephone: (            ) ________________________________  Postal Code: ________________________________
Signature: ___________________________________________  Telephone: (            ) ________________________________
Billing #:_____________________________________________

Home Address: ________________________________  Languages Spoken:
__________________________________________________  Interpreter required:  ☐ yes  ☐ no
__________________________________________________  Substitute Decision Maker (if applicable): ________________________________
__________________________________________________  ____________________________________________
Postal Code: ________________________________  Telephone: (            ) ________________________________

MEDICAL STAFF INVOLVED:

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*** PLEASE ATTACH ALL RELEVANT CONSULT REPORTS ***
MEDICAL INFORMATION

Name: ________________________________

Diagnosis: ____________________________________________

Seizures: □ yes □ no Dates: __________________________ Describe: __________________________

Loss of consciousness: □ yes □ no Coma length: __________________________

CT/MRI Results: ______________________________________ Date of completion: ______ / ______ / ______

Past & relevant medical history: _________________________________________________________________

Previous history of ABI: □ yes □ no Describe: ______________________________________________________

Pre-Injury History of Substance Abuse: □ yes □ no □ history not available

Current Substance Abuse: □ yes □ no □ not known Substance Abuse Treatment Recommended: □ yes □ no

Current psychiatric status: __________________________ Psychiatric consult notes: □ included □ to follow

Current treatment providers: _________________________________________________________________

Current Medication (or attach record): _____________________________________________________________

Allergies: ____________________________________________________________

Primary reason(s) for referral: _________________________________________________________________

PRESENTING SYMPTOMS

PHYSICAL ISSUES:

Paresis/paralysis: □ □
Medication management: □ □
Pain: □ □
Headaches: □ □
Fatigue: □ □
Dizziness: □ □
Sleep disturbances: □ □

PSYCHOSOCIAL/BEHAVIOURAL ISSUES:

Impulse control: □ □
Mood disorder: □ □
Thought disorder: □ □
Aggressiveness: □ □
Sexually inappropriate: □ □
Suicidal risk: □ □

COGNITIVE STATUS:

Orientation: □ □ □
Motivation/initiation: □ □ □
Judgement: □ □ □
Memory (short term): □ □ □
Memory (long term): □ □ □
Attention: □ □ □
Frustration tolerance: □ □ □
Insight: □ □ □
Perception: □ □ □

Comments (IDENTIFY RISK ISSUES)
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: ____________________________

_____________ / ________ / ________

___________________________________________________________
print name

Date: ____________________________

_____________ / ________ / ________

___________________________________________________________
signature

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

Witness: ____________________________

___________________________________________________________
print name

Date: ____________________________

_____________ / ________ / ________

___________________________________________________________
signature

*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.

This page completed by: ____________________________

___________________________________________________________
print name

signature

_____________ / ________ / ________

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 May 2012.