Toronto abi Network

ABI *Community Profile* Referral Checklist

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

Did you know?

The Ontario Neurotrauma Foundation (ONF) released updated Guidelines for Concussion/Mild Traumatic Brain Injury and Persistent Symptoms (Second Edition) in September 2013.

To access a copy, please visit: http://onf.org/documents/guidelines-for-concussion-mtbi-persistent-symptoms-second-edition

† *If you have any questions, please contact the Toronto ABI Network at 416-597-3057*

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MUST include all relevant brain injury medical and consult reports
(e.g. 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 Profile*

FAX TO: (416) 597-7021

Client's E-mail: _____

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

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

Diagnosis: _____

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)* _____

Primary Reason for Referral /Goal(s): _____

Number of visits since most recent head injury: to Emergency Department _____ (Specify Site)_____
to Family Doctor _____

Referral Destination: *For more details on the Ministry/LHIN funded programs below, click on the respective link.*

CLINICS

❒ Head Injury Clinics:
- ❒ St. Michael's Hospital (< 1 year post injury)
- ❒ Sunnybrook Health Sciences Centre (< 3 months post injury & have psychosocial issues)

❒ Neuropsychiatry Consultation:
- ❒ St. Michael's Hospital
- ❒ Toronto Western Hospital/UHN (ABI Clinic)

❒ Neuropsychology Clinic (CHIRS)

OUTPATIENT REHAB

❒ Toronto Rehab/UHN (< 2 years post injury & require 2 services)
Sites: ❒Rumsey (*Bayview & Eglinton*) or ❒University Centre (*University & Dundas*)

❒ Bridgepoint Active Healthcare – Sinai Health System (< 1 year post injury; includes Physiatry consultation)

COMMUNITY

❒ CCAC ABI Program (ABI services ONLY for those who live in Toronto Central & Central LHIN, < 5 years post injury)

❒ CHIRS → ❒Adult Day Services ❒Community Support Services ❒Residential Services ❒Clinical Groups ❒Substance Abuse and Brain Injury (SUBI) ❒ODSP-Employment Supports

❒ Cota → ❒ABI Case Management ❒Supportive Housing (*Collegeview*) ❒Adult Day Service (*Providence*)

❒ PACE Independent Living → ❒The Learning Network – Adult Day Services ❒Supportive Housing

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

OTHER: For referrals to Holland Bloorview Kids Rehabilitation and Ontario Shores Centre for Mental Health Sciences, download their respective forms and submit directly to these organizations.

Home Address: _____

_____

City:_____ Postal Code: _____

Primary Tel Number: ( ) _____

Alternate Tel Number: ( )_____

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

Accommodation:
☐ house ☐ apartment building ☐ supportive house
☐ rooming house ☐ other _____

Alternate contact person & phone number: _____

Relationship to Patient: SDM ☐ POA ☐ Spouse ☐

Other:_____

Client's Name: _____

Referring Physician: _____
(Most responsible physician only, do not include Medical Residents)

Address: _____

City:_____ Postal Code: _____

Tel: ( ) _____

Fax: ( ) _____

Signature* : _____

Billing # *_____

***** *Required for Clinics and Outpatient Rehab services only*

Family Physician: _____

Address: _____

City:_____ Postal Code: _____

Tel: ( ) _____

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	***Comments or Other Issues:***
Eating/drinking:	☐	☐	
Dressing:	☐	☐	
Bathing:	☐	☐	
Toileting *(including continence):*	☐	☐	
Grooming:	☐	☐	Identified risk(s):
Paresis/paralysis:	☐	☐	
Medication management:	☐	☐	
Pain/headaches:	☐	☐	
Fatigue:	☐	☐	
Sleep disturbances:	☐	☐	

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

MOBILITY:	NON-ISSUE	ISSUE	***Comments or Other Issues:***
Walking:	☐	☐	
Wheelchair:	☐	☐	
Transfers:	☐	☐	
Outdoor mobility:	☐	☐	Identified risk(s):
Falls/history of falls:	☐	☐	
Stamina:	☐	☐	
Balance/dizziness:	☐	☐	

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

INSTRUMENTAL NEEDS:	NON-ISSUE	ISSUE	***Comments or Other Issues:***
Meal preparation:	☐	☐	
Housekeeping:	☐	☐	
Shopping:	☐	☐	Identified risk(s):
Financial management:	☐	☐	

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

BEHAVIOUR ISSUES:	NON-ISSUE	ISSUE	***Comments or Other Issues:***
Ability to adjust to change:	☐	☐	
Impulse control:	☐	☐	
Mood disorder:	☐	☐	
Thought disorder:	☐	☐	
Wandering:	☐	☐	
Aggressiveness:	☐	☐	Identified risk(s):
Sexually inappropriate:	☐	☐	
Suicidal risk:	☐	☐	
Agitation:	☐	☐	
Easily Angered:	☐	☐	
Frustration Tolerance:	☐	☐	

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

COMMUNICATION:	NON-ISSUE	ISSUE	***Comments or Other Issues:***
Hearing:	☐	☐	
Vision:	☐	☐	
Language, comprehension:	☐	☐	
Language, expression:	☐	☐	Identified risk(s):
Pragmatics/conversational skills:	☐	☐	
Swallowing:	☐	☐ *(specify diet, food texture)*	

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

COGNITIVE STATUS:	NOT TESTED	INTACT	IMPAIRED	***Comments or Other Issues:***
Orientation:	☐	☐	☐	
Motivation/initiation:	☐	☐	☐	
Judgement:	☐	☐	☐	
Memory (short term):	☐	☐	☐	
Memory (long term):	☐	☐	☐	
Attention:	☐	☐	☐	Identified risk(s):
Follow instructions:	☐	☐	☐	
Insight:	☐	☐	☐	
Perception:	☐	☐	☐	

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

This referral was completed by (*name*) _____ on (*date*) _____