

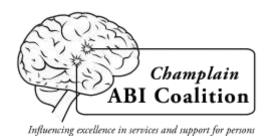
Champlain ABI Coalition

Application for Services

The following information <u>must be included</u> (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) †
☐ IMPORTANT - The following documentation is required:
Medical notes confirming the diagnosis of 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.

Please return the completed application form using the attached cover sheet to:
Ontario Health atHome
Constance Coburn
Champlain ABI System Navigator
4200 Labelle Street, Suite 100

Ottawa, ON K1J 1J8 613-745-5525 ext: 5963



living with the effects of an acquired brain injury

Fax

То	Constance Coburn, Champlain ABI System Navigator				
Organization	Ontario Health atHome				
Fax Number	613-745-6984 OR 1-855-450-8569				
Date					
Subject	ABI Application for Services				
From					
Number of page(s) (including cover)					

Comments/Commentaires:

The information contained in this communication is private and confidential, intended only for the named recipient(s). If received in error, please notify the sender by telephone immediately and keep the information in a secure manner until further direction is given by the sender. Do not copy the information or disclose it to any other person.

Client's E-mail:						
Client's Name:			☐ male ☐ female			
	surname	given name(s)				
Health Card #:		Version: Date of Birth:	// 			
Diagnosis:			☐ Concussion/mTBI			
	vent://					
Nature/Type of Injury/Event:						
injury/Event.	☐ trauma-other (specify) ☐ non-trauma (specify)					
Primary Reason fo	or Referral /Goal(s):					
Services/Support	Requested:					
□Community S	Services / Outreach	I Residential				
□Day Program	☐Anger Management Group					
Home Address: _		Home Living Situation:				
		□ alone □ with others (specify)				
City:		Accommodation: ☐ homeless ☐ at risk of homelessness ☐ house ☐ apartment building ☐ supportive house				
Postal Code:		□ board & care □ other				
		Alternate contact person & phone number	er:			
Primary Tel Numbe	er: ()	Relationship to Patient: SDM □ POA □ Spouse □				
Alternate Tel Numb	per: ()	Other:Marital Status:				

Client's Name: Health Card No: VC:				
Family Physician	<u> </u>	Tel: ()	
			,	-
	Postal Code:	гах. ()	
O.ty	ootal oodo			
Referral Source:	Contact name/position:	Phone: ()	
		 Pager/email: ()	
	Organization:		,	
Client is Currently	y: □ at home □ other (specify):			
If client in hospital,	please provide: Date of Admission:		Planned Date of D	Discharge:
Current Subst Previous psyc Current psych Allergies Seizures:	tory of Substance Abuse:	no history not available nown Substance Abuse Tr	Status on admi	nended: □ yes □ no
	FORMATION	NOTES ATTACHED		
	HISTORY INCLUDING CURR			
	hysician/Therapies		(year/month/day)	Contact Name and Number
Client will be t	ATION: (Please note: For most progra travelling: ☐ Independently ☐ Wit ☐ yes ☐ no Para #:	th Assistance	on resources avail	lable)
Languages Sp	ooken:		Interpreter re	equired:
SOCIAL INF	ORMATION			
Source: □ WSIB	NFORMATION: ☐ CPP ☐ Auto Insurance ☐ On			STD □LTD

Client's Name:	Health Card No:			No:	VC:	
Previous or Current Involvement with the Justice System? ☐ yes ☐ no Details:						
LFUNCTIONAL INFORMATION						
Where possible, please indicate	e the level o	of assista	nce needed i	n a day: (e.g. 2 hours for bathing,	toileting & grooming)	
BASIC PERSONAL ISSUES:	NON-ISSUE	ISSUE	Comn	nents or Other Issues:	Completed by:	
Eating/drinking: Dressing: Bathing: Toileting (including continence): Grooming: Paresis/paralysis: Medication management: Pain/headaches: Fatigue: Sleep disturbances:	0		ldenti	fied risk(s):	□ OT □ Nurse □ PT □ Other □ SW □ SLP □ MD	
MOBILITY:	NON-ISSUE	ISSUE	Comn	nents or Other Issues:	Completed by:	
Walking: Wheelchair:					□ OT □ Nurse □ PT □ Other	
Transfers: Outdoor mobility: Falls/history of falls: Stamina: Balance/dizziness:	_ _ _ _		Identified risk(s):		□ МЪ	
INSTRUMENTAL NEEDS:	NON-ISSUE	ISSUE	Comn	nents or Other Issues:	Completed by:	
Meal preparation: Housekeeping:					□ OT □ Nurse □ PT □ Other	
Shopping: Financial management:			Identif	ed risk(s):	□ MD	
BEHAVIOUR ISSUES: Ability to adjust to change:	NON-ISSUE	ISSUE	Comn	nents or Other Issues:	Completed by:	
Impulse control: Mood disorder: Thought disorder: Wandering: Aggressiveness: Sexually inappropriate: Suicidal risk: Agitation: Easily Angered: Frustration Tolerance:				ied risk(s):	□ PT □ Other □ SW □ SLP □ MD	
COMMUNICATION:	NON-ISSUE	ISSUE	Comn	nents or Other Issues:	Completed by:	
Hearing: Vision: Language, comprehension: Language, expression: Pragmatics/conversational skills: Swallowing:	0		Identif	ed risk(s): ure)	□ OT □ Nurse □ PT □ Other □ SW □ SLP □ MD	
	OT TESTED	INTACT	IMPAIRED	Comments or Other Issues:		
Orientation: Motivation/initiation: Judgement: Memory (short term): Memory (long term): Attention: Follow instructions: Insight: Perception:	0 0 0 0		0 0 0 0	Identified risk(s):	Completed by: OT □ Nurse □ PT □ Other □ SW □ SLP	
I certify that the above mentioned information is correct to the best of my knowledge.						
Signature:				-		

(Applicant/Substitute Decision Maker) (DD/MM/YY) Page 3 of 3