Champlain ABI Coalition

Influencing excellence in services and support for persons living with the effects of an acquired brain injury

Champlain ABI Coalition

Application for Services

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**)* †

❑ **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

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Fax

To	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 :

MUST include all relevant brain injury medical and consult reports
The referral will be returned if the above is not included.

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: _____/_____/_____

year *month* *day*

Was this injury/event work-related? ☐ yes

Nature/Type of Injury/Event:

☐ mvc

☐ trauma-other *(specify)* _____

☐ non-trauma *(specify)* _____

Primary Reason for Referral /Goal(s): _____

Services/Support Requested:

❒Community Services / Outreach ❒Adjustment Group ❒Residential

❒Day Program ❒Anger Management Group

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: _____

Marital Status: _____

Client's Name:_____ Health Card No:_____ VC:_____

Family Physician:_____ Tel: ( )_____

Address:_____ Fax: ( )_____

City:_____ Postal Code: _____

Referral Source: Contact name/position: _____ Phone: ( )_____

Organization: _____ Pager/email: ( )_____

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

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

Para-Trans: ☐ yes ☐ no **Para** #:_____

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:_____ Health Card No:_____ VC:_____

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
☐ 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
☐ 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:
☐ 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

I certify that the above mentioned information is correct to the best of my knowledge.

Signature:_____ Date: _____

(Applicant/Substitute Decision Maker) (DD/MM/YY)