

Champlain ABI Coalition

Application for Services

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

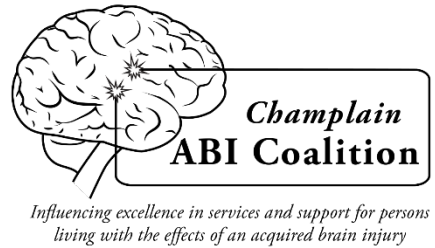
- Patient's Address, Phone Number and E-mail
- Patient's Health Card Number
- Diagnosis
- Date of Injury/Event
- Primary reason for referral
- Referral Destination (*only publicly funded services/programs are listed*) †

- 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:

Champlain LHIN
Attention: Suzanne McKenna
Champlain ABI System Navigator
4200 Labelle Street, Suite 100
Ottawa, ON K1J 1J8
613-745-5525 ext: 5963



Fax

To	Suzanne McKenna, Champlain ABI System Navigator
Organization	Champlain LHIN
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.

**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: *if any* _____ Date of Birth: / /
year *month* *day*

Diagnosis: _____ <input type="checkbox"/> Concussion/mTBI	
Date of Injury/Event: <u> </u> / <u> </u> / <u> </u> <i>year</i> <i>month</i> <i>day</i>	Was this injury/event work-related? <input type="checkbox"/> yes
Nature/Type of <input type="checkbox"/> MVC	
Injury/Event: <input type="checkbox"/> trauma-other (specify) _____	
<input type="checkbox"/> 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: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> history not available	Status on admission: _____
Current Substance Abuse: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not known	Substance Abuse Treatment Recommended: <input type="checkbox"/> yes <input type="checkbox"/> no
Previous psychiatric history: <input type="checkbox"/> yes <input type="checkbox"/> no	Describe: _____
Current psychiatric status: _____	

Allergies
Seizures: <input type="checkbox"/> yes <input type="checkbox"/> 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: <i>(Please note: For most programs there are no transportation resources available)</i>
Client will be travelling: <input type="checkbox"/> Independently <input type="checkbox"/> With Assistance
Para-Trans: <input type="checkbox"/> yes <input type="checkbox"/> no Para #: _____

Languages Spoken: _____ Interpreter required: <input type="checkbox"/> yes <input type="checkbox"/> no

SOCIAL INFORMATION

FINANCIAL INFORMATION:
Source:
<input type="checkbox"/> WSIB <input type="checkbox"/> CPP <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Ontario Works <input type="checkbox"/> ODSP <input type="checkbox"/> EI <input type="checkbox"/> OAS <input type="checkbox"/> STD <input type="checkbox"/> LTD
<input type="checkbox"/> Other _____
Status <i>(initiated, date submitted, approved):</i> _____

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:					Comments or Other Issues:	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP <input type="checkbox"/> MD
Eating/drinking:	<input type="checkbox"/>	<input type="checkbox"/>				
Dressing:	<input type="checkbox"/>	<input type="checkbox"/>				
Bathing:	<input type="checkbox"/>	<input type="checkbox"/>				
Toileting (including continence):	<input type="checkbox"/>	<input type="checkbox"/>				
Grooming:	<input type="checkbox"/>	<input type="checkbox"/>		Identified risk(s):		
Paresis/paralysis:	<input type="checkbox"/>	<input type="checkbox"/>				
Medication management:	<input type="checkbox"/>	<input type="checkbox"/>				
Pain/headaches:	<input type="checkbox"/>	<input type="checkbox"/>				
Fatigue:	<input type="checkbox"/>	<input type="checkbox"/>				
Sleep disturbances:	<input type="checkbox"/>	<input type="checkbox"/>				
MOBILITY:					Comments or Other Issues:	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> MD
Walking:	<input type="checkbox"/>	<input type="checkbox"/>				
Wheelchair:	<input type="checkbox"/>	<input type="checkbox"/>				
Transfers:	<input type="checkbox"/>	<input type="checkbox"/>				
Outdoor mobility:	<input type="checkbox"/>	<input type="checkbox"/>		Identified risk(s):		
Falls/history of falls:	<input type="checkbox"/>	<input type="checkbox"/>				
Stamina:	<input type="checkbox"/>	<input type="checkbox"/>				
Balance/dizziness:	<input type="checkbox"/>	<input type="checkbox"/>				
INSTRUMENTAL NEEDS:					Comments or Other Issues:	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> MD
Meal preparation:	<input type="checkbox"/>	<input type="checkbox"/>				
Housekeeping:	<input type="checkbox"/>	<input type="checkbox"/>				
Shopping:	<input type="checkbox"/>	<input type="checkbox"/>		Identified risk(s):		
Financial management:	<input type="checkbox"/>	<input type="checkbox"/>				
BEHAVIOUR ISSUES:					Comments or Other Issues:	Completed by: <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP <input type="checkbox"/> MD
Ability to adjust to change:	<input type="checkbox"/>	<input type="checkbox"/>				
Impulse control:	<input type="checkbox"/>	<input type="checkbox"/>				
Mood disorder:	<input type="checkbox"/>	<input type="checkbox"/>				
Thought disorder:	<input type="checkbox"/>	<input type="checkbox"/>				
Wandering:	<input type="checkbox"/>	<input type="checkbox"/>				
Aggressiveness:	<input type="checkbox"/>	<input type="checkbox"/>		Identified risk(s):		
Sexually inappropriate:	<input type="checkbox"/>	<input type="checkbox"/>				
Suicidal risk:	<input type="checkbox"/>	<input type="checkbox"/>				
Agitation:	<input type="checkbox"/>	<input type="checkbox"/>				
Easily Angered:	<input type="checkbox"/>	<input type="checkbox"/>				
Frustration Tolerance:	<input type="checkbox"/>	<input type="checkbox"/>				
COMMUNICATION:					Comments or Other Issues:	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP <input type="checkbox"/> MD
Hearing:	<input type="checkbox"/>	<input type="checkbox"/>				
Vision:	<input type="checkbox"/>	<input type="checkbox"/>				
Language, comprehension:	<input type="checkbox"/>	<input type="checkbox"/>				
Language, expression:	<input type="checkbox"/>	<input type="checkbox"/>		Identified risk(s):		
Pragmatics/conversational skills:	<input type="checkbox"/>	<input type="checkbox"/>				
Swallowing:	<input type="checkbox"/>	<input type="checkbox"/>	(specify diet, food texture)			
COGNITIVE STATUS:					Comments or Other Issues:	Completed by: <input type="checkbox"/> OT <input type="checkbox"/> Nurse <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/> SW <input type="checkbox"/> SLP
Orientation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Motivation/initiation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Judgement:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Memory (short term):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Memory (long term):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Attention:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Identified risk(s):		
Follow instructions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Insight:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Perception:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

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

Signature: _____ Date: _____