



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:

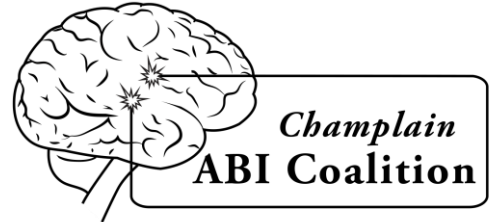
- Patient's Address, Phone Number and E-mail
- Patient's Health Card Number
- Diagnosis
- Date of Injury/Event
- Primary reason for referral
- Referral Destination (*only publicly funded services/programs are listed*) †

- 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:

Home and Community Care Support Services Champlain
Attention: Suzanne McKenna
Champlain ABI System Navigator
4200 Labelle Street, Suite 100
Ottawa, ON K1J 1J8
613-745-5525 ext: 5963



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Fax

To	Suzanne McKenna, Champlain ABI System Navigator
Organization	Home and Community Care Support Services Champlain
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 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: (Please note: For most programs there are no transportation resources available)
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 (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:	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"/>	Identified risk(s):		
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"/>			
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:	NON-ISSUE	ISSUE	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"/>	Identified risk(s):		
Wheelchair:	<input type="checkbox"/>	<input type="checkbox"/>			
Transfers:	<input type="checkbox"/>	<input type="checkbox"/>			
Outdoor mobility:	<input type="checkbox"/>	<input type="checkbox"/>			
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:	NON-ISSUE	ISSUE		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"/>	Identified risk(s):		
Housekeeping:	<input type="checkbox"/>	<input type="checkbox"/>			
Shopping:	<input type="checkbox"/>	<input type="checkbox"/>			
Financial management:	<input type="checkbox"/>	<input type="checkbox"/>			
BEHAVIOUR ISSUES:	NON-ISSUE	ISSUE		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"/>	Identified risk(s):		
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"/>			
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:	NON-ISSUE	ISSUE	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"/>	Identified risk(s):		
Vision:	<input type="checkbox"/>	<input type="checkbox"/>			
Language, comprehension:	<input type="checkbox"/>	<input type="checkbox"/>			
Language, expression:	<input type="checkbox"/>	<input type="checkbox"/>			
Pragmatics/conversational skills:	<input type="checkbox"/>	<input type="checkbox"/>			
Swallowing:	<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/> (specify diet, food texture)			
COGNITIVE STATUS:	NOT TESTED	INTACT	IMPAIRED	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"/>	Identified risk(s):	
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"/>		
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: _____