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:**

**Champlain LHIN**
**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 | 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 :

**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)