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*)

- ❑ Patient has been informed that they are responsible for arranging their own transportation to and from the programs and services requested.
- ❑ Patient 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 :

Is this an application for transitional care with:

Vista Centre Brain Injury Services _____

Pathways to Independence _____

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

Patient's Name: _____ _____ ☐ male ☐ female
surname *given name(s)*

Health Card #: _____ **Version**: _____ **Date of Birth:** _____/_____/_____
if any *year* *month* *day*

Patient's E-mail: _____

Marital Status_____

Diagnosis:_____ ☐ Concussion/mTBI

Date of Injury/Event:_____/_____/_____
year *month* *day*

Was this injury/event work-related? ☐ yes

Nature/Type of ☐ trauma-mvc/other *(specify)* _____

☐ non-trauma *(specify)* _____

Primary Reason for Referral _____

Services/Support Requested:

❒Community Services / Outreach ❒Adjustment Group ❒Residential

❒Day Program ❒Anger Management Group

❒City of Ottawa Day Program/Post Stroke Program ❒City of Ottawa LINK _____

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:

MEDICAL INFORMATION

Previous & Relevant Medical History: _____

Previous history of ABI: ☐ yes ☐ no Describe: _____

Pre or post-accident trauma : _____

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

Family Physician:_____ Tel: ( )_____

Address:_____ Fax: ( )_____

City:_____ Postal Code: _____

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

Organization: _____ Pager/email: ( )_____

Patient is Currently: ☐ at home ☐ other (specify): _____

If client in hospital: **Date of Admission:**_____ **Planned Date of Discharge**:_____

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*)

Patient 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*): _____

Do you have a substitute decision maker or power of attorney ? If so who ? _____

Contact number for SDM or POA? _____

Patient'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:	☐	☐	
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:	☐	☐	
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:	☐	☐	
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:	☐	☐	
Sexually inappropriate:	☐	☐	
Suicidal risk/ ideation	☐	☐	
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:	☐	☐	
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:	☐	☐	☐	
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)

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

Describe a typical day since your accident:

What activities do you enjoy or participate in?

What things do you struggle with?

Do you have personal spiritual beliefs that help you cope with stress? Are you part of a spiritual religious community?

What are some goals that you would like to accomplish?

Do you have any triggers that consistently cause you to be frustrated or angry?

What things do you find are calming when you are upset, angry or distressed?

What would someone need to know about you to deliver the best possible care?

What days of the week would be most convenient for you to participate in programs?