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:

Home and Community Care Support Services Champlain
Attention: 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	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 :

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 ❒City of Ottawa 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: _____

Champlain regional ABI roommate registry:

Please check this box if you would like your name to be added to the Champlain regional ABI roommate registry. By checking this box, you are providing consent for your background information to be shared with others seeking a roommate, and you will have access to the registry for your review. Your name and contact information will remain anonymous until you/other find a match and agree to establish contact. Your name can be removed from this list at any time by contacting the ABI navigator.

☐ **Yes, I provide consent to including my background information on the roommate registry.**

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)