

NEW UPDATE

As of January 23, 2018, Cota will now receive **all ABI Network referrals** for TC LHIN Home and Community Care **ABI programs**. Cota will assess each referral to determine the appropriate services and will refer directly to Home and Community Care for ABI rehab services. See page 2, under Community – Cota programs.

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**) †
- Physician's Signature and Physician's Billing Number (*only if requesting Clinic or Outpatient Rehab services*)
- *IMPORTANT*** the following medical and rehab documentation is required:
 - Medical notes
 - Consult reports
 - Initial and most recent MRI Scans, CT Scans, and/or imaging reports related to the 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.

FAX TO: 416-597-7021

Did you know?

The Ontario Neurotrauma Foundation (ONF) released *Standards for Post-Concussion Care: From Diagnosis to the Interdisciplinary Concussion Clinic* in June 2017.

For more information, please visit: <http://concussionsontario.org/>

† *If you have any questions, please contact us at 416-597-3057*

MUST include all relevant brain injury medical and consult reports (e.g. initial and most recent imaging Reports, Emergency Room Records and/or Hospital Admission/Discharge Notes). The referral will be returned if the above is not included.

ABI Community Profile

FAX TO: (416) 597-7021

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: ____/____/____ Was this injury/event work-related? yes
year month day

Nature/Type of Injury/Event: MVC MVC (motorcycle) MVC (on bicycle/pedestrian) fall assault sporting
 trauma-other (specify) _____ unknown
 non-trauma (specify) _____

Primary Reason for Referral /Goal(s): _____

Number of visits since most recent head injury: to Emergency Department _____ Specify ED Site: _____
to Family Doctor _____

Referral Destination: For more details on the Ministry/LHIN funded programs below, click on the respective link.

CLINICS Head Injury Clinics: Sunnybrook (< 3 mths post injury, complicated mild to mod TBI with positive findings on brain imaging or GCS≤14 or facial/skull/cervical fracture; Toronto Rehab/UHN Physiatry Clinic (< 1 year post injury)

Neuropsychiatry Consultation: Toronto Rehab/UHN St. Michael's Hospital (ONLY if within catchment area: south of Bloor/Danforth to Lake Ontario and east of Yonge St. to West of Victoria Park Ave.)

Neuropsychology Clinic (CHIRS) (> 1 yr post injury, ONLY if in Toronto Central or Central LHIN)

OUTPATIENT REHAB Bridgepoint Sinai Health System (< 1 yr post injury; includes Physiatry consultation)
 Toronto Rehab/UHN (< 2 yrs post injury, require 2 services, must have evidence on CT/MRI)
Sites: Rumsey (Bayview & Eglinton) or University Centre (University & Dundas)

COMMUNITY

[Central LHIN Home & Community Care](#) ABI programs (< 5 years post injury)

[CHIRS](#) Adult Day Services Community Support Services Residential Services Substance Abuse and Brain Injury (SUBI)
 Clinical Groups

[Cota](#) ABI Case Management Supportive Housing (Collegeview) Adult Day Service (Providence)
 Toronto Central LHIN Home & Community Care – Behaviour Supports & ABI programs (< 5 years post injury)

[March of Dimes Canada \(MODC\)](#) Supportive Housing ABI Community Outreach Aphasia Day Program Peer Group

[PACE Independent Living](#) Adult Day Services Supportive Housing ABI Community Program

[West Park Healthcare Centre](#) Behavioural Outreach ABI Adult Day Program

[York Simcoe Brain Injury Services \(Mackenzie Health/MODC\)](#) Behavioural Consultant Case Manager Rehab Worker
 Adult Day Program

OTHER: For referrals to [Holland Bloorview Kids Rehabilitation](#) and [Ontario Shores Centre for Mental Health Sciences](#), please submit directly to these organizations.

<p>Home Address: _____</p> <p>City: _____ Postal Code: _____</p> <p>Primary Tel Number: () _____</p> <p>Alternate Tel Number: () _____</p>	<p>Home Living Situation: <input type="checkbox"/> alone <input type="checkbox"/> with others (specify) _____</p> <p>Accommodation: <input type="checkbox"/> homeless <input type="checkbox"/> at risk of homelessness <input type="checkbox"/> house <input type="checkbox"/> apartment building <input type="checkbox"/> supportive house <input type="checkbox"/> board & care <input type="checkbox"/> other _____</p> <p>Alternate contact person & phone number: _____</p> <p>Relationship to Patient: SDM <input type="checkbox"/> POA <input type="checkbox"/> Spouse <input type="checkbox"/></p> <p>Other: _____</p>
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Client's Name: _____

Referring Physician: _____ <i>(Most responsible physician only, do not include Medical Residents)</i> Address: _____ City: _____ Postal Code: _____ Tel: () _____ Fax: () _____ Signature* : _____ Billing # * _____ <p style="text-align: center;"><small>* Required for Clinics and Outpatient Rehab services only</small></p>	Family Physician: _____ Address: _____ City: _____ Postal Code: _____ Tel: () _____ Billing #: _____
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Referral Source: Contact name/position: _____ Phone: () _____
 Organization: _____ Pager/E-mail: _____

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: _____

Is individual on antibiotics? yes no If yes, why: _____

Does individual have: MRSA VRE TB C-Difficile Other: _____

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

Wheel-Trans: yes no **Wheel-Trans #:** _____ **YRT Mobility Plus:** yes no

Has the Ministry of Transportation been informed of the injury? yes no By whom? _____

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: _____

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: Identified risk(s):	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:	NON-ISSUE	ISSUE	<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"/>						
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: Identified risk(s):	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		
Walking:	NON-ISSUE	ISSUE	<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"/>						
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: Identified risk(s):	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		
Meal preparation:	NON-ISSUE	ISSUE	<input type="checkbox"/>	<input type="checkbox"/>				
Housekeeping:	<input type="checkbox"/>	<input type="checkbox"/>						
Shopping:	<input type="checkbox"/>	<input type="checkbox"/>						
Financial management:	<input type="checkbox"/>	<input type="checkbox"/>						
BEHAVIOUR ISSUES:					Comments or Other Issues: Identified risk(s):	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		
Ability to adjust to change:	NON-ISSUE	ISSUE	<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"/>						
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: Identified risk(s):	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:	NON-ISSUE	ISSUE	<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"/>						
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: Identified risk(s):	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		
Orientation:	NOT TESTED	INTACT	IMPAIRED	<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"/>					
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"/>					

This referral was completed by (name) _____ on (date) _____