

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 updated Guidelines for Concussion/Mild Traumatic Brain Injury and Persistent Symptoms (Second Edition) in September 2013.

To access a copy, please visit: www.onf.org

† If you have any questions, please contact the Toronto ABI Network at 416-597-3057

Client's Name: _____

Referring Physician: _____ <i>(Most responsible physician only, do not include Medical Residents)</i>	Family Physician: _____
Address: _____	Address: _____
City: _____ Postal Code: _____	City: _____ Postal Code: _____
Tel: () _____	Tel: () _____
Fax: () _____	Billing #: _____
Signature* : _____	
Billing # * _____	
<i>* Required for Clinics and Outpatient Rehab services only</i>	

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:	NON-ISSUE	ISSUE	Comments or Other Issues:
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"/>	

Completed by:
 OT Nurse
 PT Other
 SW SLP
 MD

MOBILITY:	NON-ISSUE	ISSUE	Comments or Other Issues:
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"/>	

Completed by:
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 PT Other
 SW SLP
 MD

INSTRUMENTAL NEEDS:	NON-ISSUE	ISSUE	Comments or Other Issues:
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"/>	

Completed by:
 OT Nurse
 PT Other
 SW SLP
 MD

BEHAVIOUR ISSUES:	NON-ISSUE	ISSUE	Comments or Other Issues:
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"/>	

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 PT Other
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COMMUNICATION:	NON-ISSUE	ISSUE	Comments or Other Issues:
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"/> (specify diet, food texture)	

Completed by:
 OT Nurse
 PT Other
 SW SLP
 MD

COGNITIVE STATUS:	NOT TESTED	INTACT	IMPAIRED	Comments or Other Issues:
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"/>	

Completed by:
 OT Nurse
 PT Other
 SW SLP
 MD

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