

ABI EARLY NOTIFICATION FORM
(For inpatient high intensity rehab only)

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

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

Postal Code of Patient's Home Residence: _____

Date of Injury/Event: _____ / _____ / _____
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) _____

Referring Facility _____

Program Name and Service _____

Referral Contact Name: _____
 Phone: _____ Pager: _____

Repatriation Information (if applicable):

Receiving Hospital & Unit: _____

Contact Information Name: _____
 Phone: _____
 Email: _____

Medical/functional information that may impact transfer. Check all that CURRENTLY applies for this patient.

Tube feed: NG Tube J Tube G Tube GJ Tube

Tracheostomy: Uncuffed Cuffed

Observer/ Restraint: specify _____

Oxygen: Intermittent Constant

Infection Control: MRSA VRE C-Difficile ESBL

Consent has been obtained from patient or SDM to submit application

FAX TO: (416) 597-7021

This page completed by: _____ print name _____ signature _____ year / month / day