Toronto abi Network

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(For inpatient regular stream rehab only)

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

Health Card # ______________________ **Version:** ______ (*if any*) **Date of Birth:** ______ / ______ / ______ (*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 8 UhY.˙ ______________________

Receiving Hospital & Unit: ______________________

Contact Information Name: ______________________

Phone: ______________________

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*)

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker. Developed January 2011. Revised September 2015.