Toronto abi Network

ABI Community Referral Form

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

CONCUSSION referrals:

Due to the high volume of referrals requesting services for concussion, response times are long. The Toronto ABI Network will contact you directly if additional information is required or to provide alternatives for services. Service providers will contact the patient directly to coordinate services if accepted.

Only the following publicly funded services listed below accept concussion referrals:

- ❑ Case Management – Cota (1 year post injury)
- ❑ Physiatry – Toronto Rehab, University Health Network (< 1 year post injury and no patients without a family doctor)
- ❑ Psychiatry – St. Michael's Hospital, Unity Health Toronto

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

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MUST include all relevant brain injury medical and consult reports
(i.e., 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 Referral Form*

FAX TO: (416) 597-7021

Client's E-mail: _____

Client's Name: _____ *surname* _____ *given name(s)* ☐ male ☐ female ☐ other

Health Card #: _____ **Version:** _____ *if any* **Date of Birth:** _____ / _____ / _____ *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 ☐ mvc *(motorcycle)* ☐ mvc *(on bicycle)* ☐ mvc (*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 publicly-funded programs below, click on the respective link.*

CLINICS **Head Injury Clinics:**

❒ Toronto Rehab/UHN Physiatry Clinic (< 1year post injury and no patients without a family doctor)

❒ Sunnybrook (< 3 mths post injury, complicated mild to mod TBI with positive findings on brain imaging or GCS≤14 or facial/skull/cervical fracture)

Neuropsychiatry Consultation: ❒ Toronto Rehab/UHN (mod to severe only) ❒ St. Michael's Hospital

Neuropsychology Assessment 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; includes Physiatry consultation)

COMMUNITY

CHIRS ❒Adult Day Services ❒Community Support Services ❒Residential Services ❒Substance Abuse and Brain Injury (SUBI) ❒Clinical Groups (note: 60 years of age and under, mod – severe injury only)

Cota ❒ABI Case Management ❒Adult Day Service (Providence) ❒ Behaviour Therapy (< 5 years post injury, only in TC LHIN) ❒ ABI Outreach Team (Scarborough only)

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, please submit directly to the organization.

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:_____

Client's Name: _____

Referring Physician: _____
(Most responsible physician only, do not include Medical Residents)

Address: _____

City:_____ Postal Code: _____

Tel: ( ) _____

Fax: ( ) _____

Signature* : _____

Billing # *_____

***** *Required for Clinics and Outpatient Rehab services only*

Family Physician: _____

Address: _____

City:_____ Postal Code: _____

Tel: ( ) _____

Billing #: _____

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***):** _____

Previous or Current Involvement with the Justice System? ☐ yes ☐ no

Details: _____

Client's Name: _____

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
☐ SW ☐ SLP
☐ 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
☐ SW ☐ SLP
☐ 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:
☐ OT ☐ Nurse
☐ 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
☐ MD

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