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 (Only for referrals < 1 year post injury. Patients must have a family doctor. Concussion injuries post MVC* are not accepted.)

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

* *Motor Vehicle Collision (MVC)*

Toronto abi Network

ABI *Community Referral Form*

FAX TO: (416) 597-7021

MUST include all relevant brain injury medical and consult reports (For example: 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.

Client's E-mail: ______________________

Sex assigned at birth: ☐ female ☐ male ☐ prefer not to answer

Client's Name: ______________________ ______________________
surname given name(s)

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 Clinic:**

❒ Toronto Rehab/UHN Physiatry Clinic (< 1 year post injury. Concussion injuries post MVC are not accepted.)

❒ Sunnybrook (< 3 months 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 (moderate to severe only)

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

OUTPATIENT REHAB ❒ Hennick Bridgepoint Hospital/Sinai Health (< 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* ❒ Smoking Treatment for Ontario Patients (STOP) Program* (* Must have reliable case management support) Note: For all CHIRS services - individual must be 60 years of age and under, moderate – severe injury only.

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

March of Dimes Canada (MODC) ❒ ABI Community Outreach ❒ Aphasia Day Program ❒ Peer Group
ABI Supportive Housing: ❒ Toronto or ❒ Newmarket

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 Information:
Name: ____________________
Phone: (   )____________________
Email: ____________________
Relationship to Patient: SDM ☐ POA ☐ Spouse ☐
Other: ____________________

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. **Revised June 2022**

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

Nicotine Dependence: ☐ yes ☐ no **Smoking Cessation Program 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: _________________________________

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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
Eating/drinking:	☐	☐
Dressing:	☐	☐
Bathing:	☐	☐
Toileting *(including continence)*:	☐	☐
Grooming:	☐	☐
Paresis/paralysis:	☐	☐
Medication management:	☐	☐
Pain/headaches:	☐	☐
Fatigue:	☐	☐
Sleep disturbances:	☐	☐

Comments or Other Issues:

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

MOBILITY:	NON-ISSUE	ISSUE
Walking:	☐	☐
Wheelchair:	☐	☐
Transfers:	☐	☐
Outdoor mobility:	☐	☐
Falls/history of falls:	☐	☐
Stamina:	☐	☐
Balance/dizziness:	☐	☐

Comments or Other Issues:

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

INSTRUMENTAL NEEDS:	NON-ISSUE	ISSUE
Meal preparation:	☐	☐
Housekeeping:	☐	☐
Shopping:	☐	☐
Financial management:	☐	☐

Comments or Other Issues:

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

BEHAVIOUR ISSUES:	NON-ISSUE	ISSUE
Ability to adjust to change:	☐	☐
Impulse control:	☐	☐
Mood disorder:	☐	☐
Thought disorder:	☐	☐
Wandering:	☐	☐
Aggressiveness:	☐	☐
Sexually inappropriate:	☐	☐
Suicidal risk:	☐	☐
Agitation:	☐	☐
Easily Angered:	☐	☐
Frustration Tolerance:	☐	☐

Comments or Other Issues:

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

COMMUNICATION:	NON-ISSUE	ISSUE
Hearing:	☐	☐
Vision:	☐	☐
Language, comprehension:	☐	☐
Language, expression:	☐	☐
Pragmatics/conversational skills:	☐	☐
Swallowing:	☐	☐ *(specify diet, food texture)*

Comments or Other Issues:

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

COGNITIVE STATUS:	NOT TESTED	INTACT	IMPAIRED
Orientation:	☐	☐	☐
Motivation/initiation:	☐	☐	☐
Judgement:	☐	☐	☐
Memory (short term):	☐	☐	☐
Memory (long term):	☐	☐	☐
Attention:	☐	☐	☐
Follow instructions:	☐	☐	☐
Insight:	☐	☐	☐
Perception:	☐	☐	☐

Comments or Other Issues:

Identified risk(s):

Completed by: ☐ OT ☐ Nurse ☐ PT ☐ Other ☐ SW ☐ SLP ☐ MD

This referral was completed by (*name*) ______________________________ on (*date*) ____________________

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