Potential ABI Rehab Candidate Form

FAX TO: (416) 597-7021

Your patient, who was recently repatriated from an acute trauma or neurosurgical hospital, has been identified as a potential candidate for specialized inpatient ABI rehab. Once your patient has progressed to rehab ready status, **a full inpatient ABI rehab referral must be completed**. Hospitals that do not use the RM&R electronic system should submit referrals through the Toronto ABI Network. **If your patient is not eligible for inpatient rehab or they are discharged home please connect with the local ABI Navigator** abinetwork.ca/for-professionals/abi-navigators.

For details on eligibility criteria, rehab locations and to access the referral form visit: abinetwork.ca/referral-forms/inpatient-forms or call 416-597-3057

Patient's name: _____ _____
Last name **First name**

Sex assigned at birth: ☐ female ☐ male ☐ prefer not to answer **Phone #:** _____

Health Card # _____ **Version:** _____ (if any) **DOB:** _____ / ____ / _____ dd / mm / yyyy

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 ☐ unknown
☐ trauma-other *(specify)* _____
☐ non-trauma *(specify)* _____

Referring Facility _____

Program Name and Service _____

Referral Contact Name: _____
Phone: _____ Ext: _____ Pager: _____

Repatriation Information:

Receiving Hospital & Unit: _____

Contact Information Name: _____
Phone: _____ Ext: _____
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
☐ Indicate if patient is medically stable/approaching medical stability (ABI Network to prioritize follow up)
Rancho Los Amigos Cognitive Scale at present: _____

Consent has been obtained from patient or SDM: ☐ to submit Potential ABI Rehab Candidate Form to the Toronto ABI Network

Connect with the local ABI Navigator regarding community based services. abinetwork.ca/for-professionals/abi-navigators

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. Updated Feb 2026