



Application For Service

225 King William St, Suite 508
Hamilton, ON L8R 1B2
Tel: 905-523-8852 Fax: 905-523-8211
Email: info@braininjuryservices.com
Web: www.braininjuryservices.com

Client Name: _____ Male Female
(Last Name, First Name)

Health Card #: _____ Version#: _____ Expiry Date: _____

Date of Birth: ____/____/____ Date of Request: ____/____/____
year month day year month day

PERSONAL INFORMATION

Address: _____ Apt. #: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Check One: Single Married Divorced

Current Living Situation: alone with others (specify) _____

Accommodation:

house group home apartment building supportive housing rooming house
 long term care facility hospital other _____

Citizenship: Canadian Permanent Resident Other

Are you a resident of Ontario? Yes No If yes, how long? _____

Language Spoken: _____ Interpreter Required: Yes No

First Nation Band Affiliation: _____

Status Number with Dept. of Indian Affairs: _____

BRAIN INJURY INFORMATION

Date of Injury: _____

Cause of Injury: (e.g. anoxia, assault, motor vehicle accident, fall, etc.)

Ontario Association of Community-Based Boards for Acquired Brain Injury Services (OACBABIS)

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the client or substitute decision maker. Revised November 14, 2007

PERSONAL SUPPORT NETWORK /EMERGENCY CONTACTS

Emergency Contact Name: _____

Relationship: _____ Email address: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____

Other Contact Name: _____

Relationship: _____ Email address: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____

REFERRING AGENT (who is making the request):

Name: _____ Phone Number _____

Name of Agency _____ Email: _____

Relationship: _____ Contact Person Yes No

TYPE OF SERVICE REQUESTED

Residential Day Services Outreach Services Other

TREATMENT HISTORY INCLUDING CURRENT SERVICES

Program/Facility/Hospital	Dates Involved (year/month/day)	Contact Name and Phone Number

LIST OF SERVICES YOU HAVE APPLIED FOR FROM OTHER AGENCIES
(e.g. Vocation Rehabilitation, Addiction Services)

Name of Facility / Program	Contact Person	Address, phone number	Status of Application

Please note that medical, attendant care, rehabilitation and vocational reports are required: Neurosurgery, Neuropsychology, Speech Therapy, Physiotherapy, Occupational Therapy, Social Work, Psychology, Psychiatry, Assessment and Discharge Summaries. If you have copies of these reports please attach to the application.

PERSONAL INFORMATION

Seizures No Yes
If yes, describe: _____

Wheelchair No Yes Manual Motorized
 Transfers Yes No
If yes, describe: _____

Assistive Devices No Yes
If yes state what is needed: _____

Attendant Care No Yes
If yes, describe: _____

Supervision or assistance with walking No Yes
If yes, does it apply to: level surfaces stairs or both

Communication Issues: No Yes
If yes, describe: _____

Other Physical Conditions (allergies, heart conditions, diet restrictions, etc) No Yes
If yes, describe: _____

Pre-Injury History of Substance Abuse: No Yes history not available
 Current Substance Abuse: No Yes not known
 Substance Abuse Treatment Recommended: No Yes
 Previous Psychiatric History: No Yes
 Describe: _____

Current Psychiatric Status: _____
 Psychiatric Consult Notes: included report to follow not available

Education: Highest grade/level attained: _____

If in school, name of school: _____

Name of Last Employer: _____

Position: _____ How long were you in this position?

FINANCIAL INFORMATION

Check Source Of Income:

- Ontario Disability Support Program (ODSP)
- Old Age Security (OAS)
- Workplace Safety Insurance Board (W.S.I.B.)
- Ontario Works (OW)
- Canadian Pension Plan (C.P.P.)
- Long Term Disability (private)

Lawyer's Name: _____
Company: _____ Phone: _____

Insurance Adjuster Name: _____
Company: _____ Phone: _____

Rehabilitation Case Manager Name: _____
Company: _____ Phone: _____

- Insurance Settlement
- Full Time Employment
- Structured Settlement
- Income Generating Assets - please describe: _____
- Inheritance
- Part Time Employment

Amount of income per month: _____

Do you have direct access to your income? Yes No **If no**, Name and Phone Number of Substitute Decision Maker/Power of Attorney and attach supporting documentation:

I, _____ certify that the above mentioned information is correct, to the best of my knowledge.

Signed (Applicant or Substitute Decision Maker) _____ Date _____

Signed (Applicant or Substitute Decision Maker) _____ Date _____			
ONTARIO COMMUNITY BASED NON-PROFIT PROGRAMS FOR ADULTS WHO LIVE WITH THE EFFECTS OF BRAIN INJURY			
Program Name (Check off agencies you have made application to)	Address	Phone Number	Fax Number
<input type="checkbox"/> Acquired Brain Injury Program – The Rehabilitation Centre	125 Scrivens St. Ottawa, ON K2B 6H3	(613) 726-1558	(613) 726-1764
<input type="checkbox"/> Brain Injury Community Re-Entry (Niagara) Inc.	261 Martindale Rd., Units 12 & 13 St. Catharines, ON L2W 1A1	(905) 687-6788 1 800 996-8796	(905) 641-2785
<input type="checkbox"/> Brain Injury Services	225 King William St., Suite 508 Hamilton, ON L8R 1B1	(905) 523-8852	(905) 523-8211
<input type="checkbox"/> Brain Injury Services of Northern Ontario	426 Balmoral St. Thunder Bay, ON P7C 5G8	(807) 623-1188	(807) 623-1201
<input type="checkbox"/> Brain Injury Services of Simcoe Muskoka	560 Bryne Dr. Unit 4 Barrie, ON L4N 9P6	(705) 734-2178 Toll Free #: 877-320-1950	(705) 734-1598
<input type="checkbox"/> Community Head Injury Resource Services of Toronto (CHIRS)	62 Finch Avenue West Toronto, ON M2N 2H4	(416) 240-8000	(416) 240-1149
<input type="checkbox"/> Dale Brain Injury Services Inc.	815 Shellborne St. London, ON N5Z 4Z4	(519) 668-0023	(519) 668-6783
<input type="checkbox"/> Peel Halton Acquired Brain Injury Services (PHABIS)	176 Robert Speck Parkway Mississauga, ON L4Z 3G1	(905) 949-4411	(905) 949-4019
<input type="checkbox"/> Vista Centre	211 Bronson Ave., Ste. 214 Ottawa, ON K1R 6H5	(613) 234-4747	(613) 234-3625



Medical Status Form
(Must be completed by a medical doctor)

_____ has applied to Brain Injury of Services. In order to approve application, form must be a completed in full.
(Name and date of birth)

Physical Status
Does the applicant require a wheelchair YES _____ NO _____ Manual _____ Motorized _____
Does the applicant require other assistive devices? Please state what is needed:
Does the applicant require attendant care? YES _____ NO _____ If yes please explain,
Does the applicant require supervision or assistance with walking? YES _____ NO _____ Does that apply to: _____ level surfaces _____ stairs _____ both
Can applicant transfer independently? YES _____ NO _____ Please describe assistance required:
Are there any communication issues? YES _____ NO _____ Please describe:
Are there any other physical conditions that should be mentioned? (allergies, heart conditions, diet restrictions, etc.) YES _____ NO _____

Medications			
Name of Medication	Dosage	Reason	Side Effects

(Add additional pages if necessary)

Medication Administration: Self _____ or Other _____, Specify who:

Seizures

Has applicant experienced a seizure? YES _____ NO _____ Date of last seizure: _____

Frequency of seizures: Daily _____ Weekly _____ Monthly _____ Other, please specify _____

Are there any interventions, pre or post seizure activity that we need to be aware of? Yes _____ No _____
If yes, please specify:

Is the applicant's **PRIMARY** diagnosis an acquired brain injury? YES _____ NO _____
If NO, please specify primary diagnosis:

Is the injury progressive or degenerative in nature? YES_____ NO_____

Please specify diagnosis:

Is there a secondary and/or dual diagnosis? YES_____ NO_____

If YES, please specify:

Are there any behavioural concerns: YES_____ NO_____

Please explain:

Is there a history of substance abuse? YES_____ NO_____

Are there current substance abuse issues? YES_____ NO_____

Please specify substance abuse issues:

DATE

Physician's Signature or Stamp:

Please return form to:

Brain Injury Services
225 King William Street, Suite 508
Hamilton, ON L8R 1B1