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: ____/____/_____
year month day

Date of Request: ____/_____/____
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: ____________________
Positon: How long were you in this position?

FINANCIAL INFORMATION

Check Source Of Income:

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

□ Lawyer's Name: ______________________________
Company: ____________________ Phone: ____________________
□ Insurance Adjuster Name: ______________________________
Company: ____________________ Phone: ____________________
□ Rehabilitation Case Manager Name: ______________________________
Company: ____________________ Phone: ____________________

□ Insurance Settlement □ Structured Settlement □ Inheritance □ Part Time Employment
□ Full Time Employment □ Income Generating Assets - please describe: ____________________
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
☐ Acquired Brain Injury Program – The Rehabilitation Centre	125 Scrivens St. Ottawa, ON K2B 6H3	(613) 726-1558	(613) 726-1764
☐ 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
☐ Brain Injury Services	225 King William St., Suite 508 Hamilton, ON L8R 1B1	(905) 523-8852	(905) 523-8211
☐ Brain Injury Services of Northern Ontario	426 Balmoral St. Thunder Bay, ON P7C 5G8	(807) 623-1188	(807) 623-1201
☐ 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
☐ Community Head Injury Resource Services of Toronto (CHIRS)	62 Finch Avenue West Toronto, ON M2N 2H4	(416) 240-8000	(416) 240-1149
☐ Dale Brain Injury Services Inc.	815 Shellborne St. London, ON N5Z 4Z4	(519) 668-0023	(519) 668-6783
☐ Peel Halton Acquired Brain Injury Services (PHABIS)	176 Robert Speck Parkway Mississauga, ON L4Z 3G1	(905) 949-4411	(905) 949-4019
☐ Vista Centre	211 Bronson Ave., Ste. 214 Ottawa, ON K1R 6H5	(613) 234-4747	(613) 234-3625

Brain Injury Services

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

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

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
Fax (905) 523-8211