

**Office Use Only**

Date Referral Received: \_\_\_\_\_

Parkwood Institute MR#: \_\_\_\_\_

**Parkwood Institute Acquired Brain Injury Program**

550 Wellington Rd. London, Ontario N6C 0A7

**Telephone:** 519 685 4064 **Fax:** (519) 685-4551 **Toll free:** 1-866-484-0445

Client Information		
Name:	Health Card #:	
Address:	Town:	Postal Code
Phone:	Date of Birth (dd/mm/yy)	Sex (circle): male female other
Marital status: <input type="checkbox"/> single, <input type="checkbox"/> married, <input type="checkbox"/> divorced, <input type="checkbox"/> separated, <input type="checkbox"/> common-law, <input type="checkbox"/> widow(er)		
Preferred language: <input type="checkbox"/> English, <input type="checkbox"/> French, <input type="checkbox"/> other: _____ Email Address: _____		

Contact person (if client not person of first contact)		
Name:	Relationship to client:	Telephone:

Reason for Referral
<input type="checkbox"/> Request referral to multi-disciplinary outpatient rehabilitation program <b>Please note: Referrals are not reviewed by physiatry.</b>
<b>Please note: If you are seeking confirmation of ABI diagnosis, a separate referral must be made to physiatry or neuropsychology. Please complete the physiatry or neuropsychology referral form found at <a href="http://www.sjhc.london.on.ca/concussion-mtbi/about-us/referral">www.sjhc.london.on.ca/concussion-mtbi/about-us/referral</a>.</b>

Multi-disciplinary ABI Outpatient Programs
<b>ABI Outpatient program:</b> Funded through Ministry of Health and <b>requires physician referral</b> . Goal-driven, one-on-one and group treatment for individuals with confirmed ABI diagnosis. Services include Occupational Therapy, Physiotherapy, Speech Language Pathology, and Social Work.
<b>ABI Outreach Program:</b> Funded through Ministry of Health and <b>does not require physician referral</b> . Consultation, support, training, and case coordination for people with an ABI, their families, caregivers, and other service providers. Focused on enabling persons with ABI to reintegrate and maintain in their own community.
<b>NeuroTrauma Rehab Program: Not funded through Ministry of Health. Appropriate for individuals who are willing to self-pay or qualify to access funding through workplace insurance (i.e., WSIB), motor vehicle insurance, or extended health benefits.</b> Individuals must be over 16 years of age, live within one of 10 Southwestern Ontario counties, and have sustained neurological trauma from accidents or disease. Services include Audiology, Occupational Therapy, Physiotherapy, Neuropsychology, Rehabilitation Therapy, Speech Language Pathology, and Social Work.
<b>Regional Coordinator of ABI Services:</b> Appropriate for individuals with a confirmed ABI diagnosis. Case management for those with multiple/complex care needs, difficulties coping with a mental health diagnosis, and/or substance use issues. The goal is to facilitate meaningful community integration for these clients.

<b>Date of Brain Injury (dd/mm/yy):</b>
<b>Cause (select appropriate below):</b>
<input type="checkbox"/> Fall <input type="checkbox"/> Assault <input type="checkbox"/> Aneurysm <input type="checkbox"/> Car collision <input type="checkbox"/> Sports Injury <input type="checkbox"/> Anoxia <input type="checkbox"/> Tumour <input type="checkbox"/> Encephalitis <input type="checkbox"/> Workplace injury <input type="checkbox"/> Other: _____
<b>If workplace injury or car collision, include the following contact information (name and telephone/fax):</b>
Claim number: _____ Case Manager/Adjustor: _____ Telephone: _____ Fax: _____
Lawyer: _____ Telephone: _____ Fax: _____

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**Presenting Difficulties**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Difficulty with memory                                 | <input type="checkbox"/> Perceptual difficulties                            | <input type="checkbox"/> Noise sensitivity                      |
| <input type="checkbox"/> Difficulty paying attention                            | <input type="checkbox"/> Swallowing Issues                                  | <input type="checkbox"/> Difficulty hearing in background noise |
| <input type="checkbox"/> Difficulty following or participating in conversations | <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Physical problems                      |
| <input type="checkbox"/> Confusion  | <input type="checkbox"/> Sleep issues                                       | <input type="checkbox"/> Pain and/or headaches                  |
| <input type="checkbox"/> Poor judgment  | <input type="checkbox"/> Depression   | <input type="checkbox"/> Problems with balance                  |
| <input type="checkbox"/> Lack of initiation                                     | <input type="checkbox"/> Vision changes (not associated with acuity or age) | <input type="checkbox"/> Dizziness/faintness                    |
| <input type="checkbox"/> Difficulty controlling emotions                        | <input type="checkbox"/> Tinnitus   | <input type="checkbox"/> Vertigo                                |

**Relevant History**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Previous brain injury      | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Substance use  | <input type="checkbox"/> Criminal offences or charges |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Violent behaviour            |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Dementia      |   |   |
| <input type="checkbox"/> Other (please list): _____ |  |   |   |
| _____   |  |   |   |

**Present Issues with**  Criminal offences or charges,  Violent behavior,  Substance use,  Mental Illness

Is there anything further you feel we should be aware of?

\_\_\_\_\_

\_\_\_\_\_

**Additional Services Received:** If aware of involvement of additional services, please indicate below

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dale Brain Injury Services | <input type="checkbox"/> Physiotherapy             | <input type="checkbox"/> Massage                        |
| <input type="checkbox"/> CCAC                       | <input type="checkbox"/> Occupational Therapy      | <input type="checkbox"/> Chiropractic                   |
| <input type="checkbox"/> CMHA                       | <input type="checkbox"/> Speech Language Pathology | <input type="checkbox"/> Social Work                    |
| <input type="checkbox"/> Psychology                 | <input type="checkbox"/> Neuropsychology           | <input type="checkbox"/> Other (please describe below): |
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Family Physician**

Name:	Phone:	Fax:
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Physician Signature (required for ABI Outpatient Program)

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**Referral Information**

Name:	Phone:	Fax:
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Position/Agency:	Date of Referral:
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**Thank you. Please Fax completed form to 519-685-4551**