Acquired Brain Injury (ABI) Outpatient (Physiatry & Allied Health) & Outreach Services

*Please note, eligibility for ALL programs **requires a diagnosed brain injury**. All services have variable wait-lists.*

Physiatry

Medical consultative services that provide recommendations and/or interventions related to ABI specific symptoms (e.g. headaches).

Eligibility Criteria	Exclusion Criteria
➢ 17 years of age or older ➢ Referral received within one year of the date of injury ➢ Symptomatic, with specific goals ➢ Mild brain injury with no access to third party funding (e.g. WSIB, MVA insurance) ➢ Any moderate or severe brain injury, regardless of funding source (i.e. OHIP or third party). Must have brain imaging with blood/major injury OR documented GCS ≤ 12	➢ Needs or goals are not related to an ABI ➢ Mild brain injuries with access to third party funding (e.g. WSIB, MVA insurance)

Allied Health

Multi-disciplinary services delivered through individual or group therapy. Disciplines include social worker, physiotherapist, speech language pathologist, occupational therapist, and rehabilitation assistant.

Eligibility Criteria	Exclusion Criteria
➢ 16 years of age or older ➢ Referral received within two years of the date of injury ➢ Capacity to benefit from a goal-oriented program	➢ Progressive or degenerative disorders ➢ Needs or goals are not related to an ABI ➢ Past or current participation in outpatient ABI therapy for the same injury ➢ Unable to participate in services due to mental, physical, or medical reasons ➢ Access to third party funding (e.g. WSIB, MVA insurance)

Outreach

Includes service organization, client-specific ABI education for families, caregivers, service providers and employers, and support (symptom management, budgeting, anger management, supportive counselling, community access, etc.). These services are delivered in the client's home and/or community.

Eligibility Criteria	Exclusion Criteria
➢ 16 years of age or older ➢ Capacity to benefit from a goal-oriented program ➢ Living in Essex, Lambton, Middlesex, Elgin, Kent, Oxford, Huron, Perth, Bruce, or Grey county	➢ Progressive or degenerative disorders ➢ Needs or goals are not related to an ABI ➢ Individuals who sustained their injury before the age of 13 ➢ Unable to participate in services due to mental, physical, or medical reasons ➢ Access to third party funding (e.g. WSIB, MVA insurance)

REFERRAL FORM

Acquired Brain Injury Outpatient (Physiatry & Allied Health) & Outreach Services

PHONE: 1-866-484-0445 **FAX**: 519-685-4824

MAILING ADDRESS: Parkwood Institute, Main Building, P.O. Box 5777, STN B, London ON. N6A 4V2

Patient Information (place sticker here)			
Last name:	First name:	Gender:	Date of birth: YYYY/MM/DD
Health card:	Version code:	Telephone: (Primary)	Telephone: (Other)
Address - # and Street:	City:	Province:	Postal Code:
Alternate contact (if different than above)	Relationship to patient	Phone number #1	Phone number #2
***REQUIRED - Date of Injury** (DD/MM/YYYY)	☐ Traumatic ☐ Non-Traumatic GCS Score: LOC: ☐ Yes ☐ No	Interpreter required: ☐ Yes ☐ No Language:	

Cause of Brain Injury				
☐ Fall	☐ Sports Injury	☐ Tumour	☐ Anoxia/Hypoxia	☐ Other:
☐ Assault	☐ Hit Head (object)	☐ Aneurysm	☐ Encephalitis	

Major Presenting Difficulties Due to Brain Injury (pick top 3)		
☐ Memory	☐ Swallowing	☐ Noise/light sensitivity
☐ Attention	☐ Communication	☐ Balance/Falls
☐ Confusion	☐ Depression and/or anxiety	☐ Lack of initiation
☐ Poor judgment	☐ Vision changes (due to injury)	☐ Fatigue
☐ Controlling emotions	☐ Tinnitus (ringing in ears)	☐ Dizziness/vertigo
☐ Sleep	☐ Following or participating in conversation	☐ Headaches
		☐ Other:

Current Concerns

☐ Suicidal/Homicidal ideation ☐ Mental health ☐ Criminal offenses or charges ☐ Aggressive/Violent behaviours

☐ Substance use Is there anything else we should be aware of?

Services Being Requested

☐ Outreach ☐ Occupational Therapy ☐ Physiatry ☐ Physiotherapy ☐ Speech Language Pathology ☐ Social Work

Please include the following information with the referral:

1. Medication list (including vitamins, OTCs and recent trials) and allergies
2. Relevant medical history, consult notes, CTs, X-rays, MRIs, ER notes, and clinical/therapy notes

Family Physician		
Name:	Phone:	Fax:

Referral source information	
Print name of Referral Source	Physician/Nurse Practitioner Signature ***REQUIRED for Outpatient Services; not required for Outreach**
Phone: (if different than above)	Fax: (if different than above)

What happens next?

We will fax the family physician (if available) within **7 business days** to confirm receipt of referral. **To expedite this process, please ensure that you have provided all requested information and contact information with this referral.** To ensure the client receives the optimal level of care/service, other programs may be determined more suitable. You will be informed if the client is referred to a different program. If you have any questions, please call 1-866-484-0445.