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TRAVERSE INDEPENDENCE

Please send completed forms and pertinent information to:

ABI Intake Coordinator – Traverse Independence
1-1382 Weber Street East, Kitchener, ON N2A 1C4
Phone 519-741-5845 – Fax 519-741-8731
Email ABIRef@travind.ca

SIMPLE REFERRAL FORM – ABI IN THE STREETS, MAINSTREAM OUTREACH AND DAY PROGRAM

APPLICANT INFORMATION

Last Name _____ First Name _____

Preferred Name

Current Housing Status

- ☐ Permanent Housing
- ☐ Unhoused
- ☐ At risk of experiencing homelessness
- ☐ Hospital
- ☐ Hospital - Acute
- ☐ Rehabilitation Treatment
- ☐ Rehabilitation treatment hospital
- ☐ Long term care facility
- ☐ Precariously Housed
- ☐ Other (please specify)

Current Address or Location

Phone Number

Email Address

Health Card Number

Date of Birth

Pronouns

REFERRAL SOURCE CONTACT INFORMATION

Last Name First Name

Organization

Phone Number

Email Address

☐ Contact Referral Source regarding this referral?

Day Program includes the Drop-in and Schedule Programs

For Administration only: Date ID

CONSIDERATIONS WHEN CONTACTING APPLICANT? (COMMUNICATION NEEDS, BEST WAY TO REACH THEM, BEST PLACE TO MEET THEM, MEDICAL NEEDS, ETC.

HELPS BRAIN INJURY SCREENING TOOL

Consumer Information: _____

_____

_____

Agency/Screener's Information: _____

_____

H Have you ever **H**it your **H**ead or been **H**it on the **H**ead? ☐ Yes ☐ No

Note: Prompt client to think about all incidents that may have occurred at any age, even those that did not seem serious: vehicle accidents, falls, assault, abuse, sports, etc. Screen for domestic violence and child abuse, and also for service related injuries. A TBI can also occur from violent shaking of the head, such as being shaken as a baby or child.

E Were you ever seen in the **E**mergency room, hospital, or by a doctor because of an injury to your head? ☐ Yes ☐ No

Note: Many people are seen for treatment. However, there are those who cannot afford treatment, or who do not think they require medical attention.

L Did you ever **L**ose consciousness or experience a period of being dazed and confused because of an injury to your head? ☐ Yes ☐ No

Note: People with TBI may not lose consciousness but experience an "alteration of consciousness." This may include feeling dazed, confused, or disoriented at the time of the injury, or being unable to remember the events surrounding the injury.

P Do you experience any of these **P**roblems in your daily life since you hit your head? ☐ Yes ☐ No

Note: Ask your client if s/he experiences any of the following problems, and ask when the problem presented. You are looking for a combination of two or more problems that were not present prior to the injury.

- ☐ headaches
- ☐ dizziness
- ☐ anxiety
- ☐ depression
- ☐ difficulty concentrating
- ☐ difficulty remembering
- ☐ difficulty reading, writing, calculating
- ☐ poor problem solving
- ☐ difficulty performing your job/school work
- ☐ change in relationships with others
- ☐ poor judgment (being fired from job, arrests, fights)

S Any significant **S**icknesses? ☐ Yes ☐ No

Note: Traumatic brain injury implies a physical blow to the head, but acquired brain injury may also be caused by medical conditions, such as: brain tumor, meningitis, West Nile virus, stroke, seizures. Also screen for instances of oxygen deprivation such as following a heart attack, carbon monoxide poisoning, near drowning, or near suffocation.

Scoring the HELPS Screening Tool

A HELPS screening is considered positive for a *possible* TBI when the following 3 items are identified:

1.) An event that could have caused a brain injury (yes to H, E **or** S), **and**
2.) A period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to L or E), **and**
3.) The presence of two or more chronic problems listed under P that were not present before the injury.

Note:

- A positive screening is **not sufficient to diagnose TBI** as the reason for current symptoms and difficulties - other possible causes may need to be ruled out
- **Some individuals could present exceptions** to the screening results, such as people who do have TBI-related problems but answered "no" to some questions
- Consider positive responses within the context of the person's self-report and documentation of altered behavioral and/or cognitive functioning

The original HELPS TBI screening tool was developed by M. Picard, D. Scarisbrick, R. Paluck, 9/91, International Center for the Disabled, TBI-NET, U.S. Department of Education, Rehabilitation Services Administration, Grant #H128A00022. The Helps Tool was updated by project personnel to reflect recent recommendations by the CDC on the diagnosis of TBI. See http://www.cdc.gov/ncipc/pub-res/tbi_toolkit/physicians/mtbi/diagnosis.htm.

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For Administration only: Date _____ ID _____

CONSENT TO COLLECT AND DISCLOSE PERSONAL HEALTH INFORMATION

Privacy: As a provider of health care services, Traverse Independence collects, uses, discloses, retains and protects personal information about you. As an agency we are committed to protecting the privacy, confidentiality, and security of all personal information that is entrusted to us. Traverse Independence is considered to be a personal health information custodian under the Ontario Personal Health Information Protection Act, 2004. (See attached Privacy Policy Statement for complete details).

Research: Traverse Independence pursues ongoing relationships with academic and research facilities. I understand that information may be gathered from my health record for research purposes, but confidentiality will be respected with no information disclosing my identity being released or published. By signing below, I acknowledge any questions have been answered to my satisfaction, and I have been informed I may refuse release of my records at any time without compromising the quality of care received from Traverse Independence by indicating in the check box below.

☐ By checking this box, I refuse the confidential release of my records to academic and research partnerships of Traverse Independence.

Consent for Personal Health Information:

This form confirms that I, or my Substitute Decision Maker, understand that to provide me with services, Traverse Independence will collect my personal health information. I recognize that I have the opportunity to ask questions about Traverse Independence's privacy policies, and I understand that there are some rare exceptions to the commitment to privacy.

I, _____

Date of Birth _____

hereby agree to the following:

- To allow Traverse Independence to collect and use personal health information about me for the purpose of assessment, research, planning, or delivering services.
- To allow documentation of a personal health nature to be reviewed by Traverse Independence internal staff for the purpose of administrative responsibilities, risk management, to maintain or improve the quality of care, or for staff education to provide health care
- To the sharing and/or exchange of information in the event that sharing is necessary because of an emergency that threatens the health or safety of myself or another individual (this includes with the Emergency Department of a hospital).

- To the disclosure to and/or exchange of written, verbal, and/or electronically transmitted information between Traverse Independence and:

If referrals to other agencies have been made, can we contact the identified agencies in order to facilitate appropriate and timely service provision?

☐ Hamilton Health Sciences ☐ Grand River Hospital

☐ Stonehenge Therapeutic Community ☐ St. Joseph's Health Care Centre Guelph

☐ CMHA ☐ Home and Community Care Support Services

☐ Guelph General Hospital ☐ Cambridge Memorial Hospital

☐ Groves Memorial Hospital ☐ North Wellington Health Care

☐ Other: ☐ Other:

Any specified restrictions:

The consent expires on the day of year

I understand that this consent may be revoked at any time, except for actions that have already been taken.

Signature of Client or Substitute Decision Maker

Signature of Witness

Dated this day of year

Or verbal consent received by

On date (mm/dd/yyyy)

translated the information on this form and verified the client's responses.

A photocopy of this authorization shall have the same validity as the original.