Traverse Independence
1-1382 Weber Street East – Kitchener, ON N2A 1C2
Phone 519-741-5845 – Fax 519-741-8731

Referral Type	☐ Internal	☐ External
Date Referral Form Completed (dd/mm/yyyy)		

REFERRAL FORM – TRANSITIONAL LIVING, GROUP HOME

ID _____

Traverse Independence is a personal health information custodian under the Ontario Personal Health Information Protection Act, 2004. We are committed to protecting the privacy, confidentiality and security of all personal information entrusted to us.

All our intake forms are available on our website www.traverseindependence.ca under ABI Services. If you have questions regarding these forms, contact the ABI Intake Coordinator for assistance. Phone 519- 741-5845 or email ABIRef@travind.ca.

DOCUMENTATION REQUIRED WITH REFERRAL FORM

☐ Consent to Release Medical Health Information – completed and signed by applicant

☐ Medical Report – completed by a physician or nurse practitioner.
Intake Coordinator will assist if neccessary.

☐ Pertinent medical information completed by current (or past – if relevant) service provider involved in applicant's care, such as OT, PT, Neurologist, etc. This information is required in referrals done by hospital, LHIN, Long Term Care facilities, mental health services, insurance, etc.

☐ Copy of Power of Attorney, if applicable

☐ Copy of photo identification card, for instance driver's license, passport, or health card

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

APPLICANT INFORMATION

Last Name | First Name

Preferred Name

Address (St + Apt #)

City/Province | Postal Code

Phone Number | Cell Number

Email Address

Health Card Number

Date of Birth

Describe your Gender

Preferred Pronouns

Preferred Communication Language

☐ English ☐ French ☐ Other (Specify)

WHO SHOULD BE CONTACTED REGARDING THIS INTAKE?

☐ Applicant

☐ Family/Support Contact

☐ Referral Person

☐ Other (Specify)

Considerations when contacting this applicant

CURRENT HOUSING STATUS

☐ Permanent/safe housing ☐ Hospital - Acute ☐ Hospital ☐ Temp Housed

☐ Homeless ☐ At risk of being homeless

☐ Long Term Care Facility ☐ Rehab Hospital ☐ Rehab Hospital

☐ Other (Specify)

FAMILY/SUPPORT CONTACT INFORMATION

Last Name | First Name

Relationship

Address (St + Apt #)

City/Province | Postal Code

Home Phone Number | Cell Number

Email Address

REFERRAL PERSON CONTACT INFORMATION

Last Name | First Name

Organization

Address (St + Apt #)

City/Province

Phone Number | Fax Number

Email Address

MEDICAL INFORMATION

Date of Brain Injury

Seizure History ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Origin of Acquired Brain Injury – please check off and/or explain

☐ Motor Vehicle Collisiion ☐ Non-Traumatic Injury ☐ Traumatic Injury

☐ Brain Tumour ☐ Stroke ☐ Concussion

☐ Other (Specify)

Provide a brief explanation

Additional Health Information/Diagnoses/Mental Health Concerns

Are you currently receiving mental health supports?

☐ Yes ☐ No

If yes, what is the name of your assigned worker?

Do we have consent to contact this organization?

☐ Yes ☐ No

Do you have a substance use disorder or addictions?

☐ Yes ☐ No

Are you connected to addiction supports?

☐ Yes ☐ No

Do we have consent to contact the organization that provides these supports?

☐ Yes ☐ No

If yes, what is the name of the organization and your assigned worker?

Are you currently experiencing homelessness or precarious housing?

☐ Yes ☐ No

Describe

Have you experienced Intimate partner violence?

☐ Yes ☐ No

Describe

Are you currently involved with probation and parole?

☐ Yes ☐ No

Describe

PHYSICIAN CONTACT INFORMATION

Primary Care Physician			
Address			
City/Province		Postal Code	
Phone Number		Fax Number	
Name of Specialist			
Specialist's Address			

City/Province _____ Postal Code _____

INCOME INFORMATION

Current Source of Income – please check.

☐ Auto Insurance ☐ Annuity ☐ Tort Action

☐ Pension Plan ☐ CPP (D) ☐ Disability STD

☐ Disability LTD ☐ ODSP ☐ WSIB

☐ Other (Specify) _____

LEGAL INFORMATION

Power of Attorney (POA) for Property

Has Applicant appointed a POA for Property?

☐ Yes ☐ No ☐ POA is not needed

If the answer is yes, a copy of the POA is required.

Name of POA _____

☐ Yes, photo ID provided

Type of ID _____

Power of Attorney (POA) for Care/SDM

Has Applicant appointed a POA for Care/SDM?

☐ Yes ☐ No ☐ POA is not needed

If the answer is yes, a copy of the POA/SDM is required.

Name of POA _____

☐ Yes, Photo ID was provided

Type of ID _____

Public Guardian and Trustee for Property (PGT)

Does Applicant have a PGT for Property?

☐ Yes ☐ No

Name of PGT _____

PGT's Address _____

City/Province _____ Postal Code _____

Phone Number _____ Fax Number _____

Email Address _____

BEFORE SUBMISSION PLEASE ENSURE YOU HAVE INCLUDED THE FOLLOWING DOCUMENTS

☐ Referral Form

☐ Current Medication

☐ Consent to Release Medical Health information - completed and signed by applicant

☐ Medical Information from Service Providers

☐ Copy of Power of Attorney - if applicable

☐ Pertinent medical information completed by current (or past - if relevant) service provider involved in applicant's care, such as OT, PT, Neurologist, etc. This information is required in referrals done by Hospital, CCAC, Long, Terms Care Facilities, Mental Health Services, Insurance, etc.

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☐ New Applicant ☐ Former Traverse Client