TRAVERSE INDEPENDENCE

REFERRAL FORM ACQUIRED BRAIN INJURY SERVICES

ID Number

Applicant Information:		
Last Name:	First Name:	Preferred Name:
Home Address - Street & Apt. #:	City & Province:	Postal Code:
Email:	Home Phone Number:	Cell Number:
Preferred Communication Language: English	French	Other:
Health Card Number:	Date of Birth: Month/ Day/ Year	Gender:
Who should be contacted regarding this intake? Applicant Family/Support Contact	Referral Person	Other

Family/ Support Person Contact Information:		
Last Name:	First Name:	Relationship:
Home Address - Street & Apt. #:	City & Province:	Postal Code:
Email:	Home Phone: Cell Number:	Work Phone Number:

Referral Source Contact Information:		
Referral Source Name:	Referral Source Phone Number:	Referral Source Fax Number:
Referral Source Address:	City & Province	Referral Source Email:

Please turn over.

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ID Number

Medical Information:	
Date of Brain Injury: Month/ Day/ Year	**Seizure History?** Yes No **Diabetes?** Yes No

Origin of Acquired Brain Injury – please check off and explain:

Motor Vehicle Collision	Non-Traumatic Injury	Traumatic Injury	
Brain Tumour	Stroke	Concussion	Other

Provide brief explanation:

Additional Health Information / Diagnoses / Concerns:

Physician Contact Information:	
Family Physician's Name:	Physician's Address:
Physician's Phone Number:	Physician's Fax Number:
Specialist's Name:	Specialist's Address:
Specialist's Phone Number:	Specialist's Fax Number:

Income Information:

Current Source of Income – please check:

Auto Insurer	CPP (D)
Annuity	Disability STD
Tort Action	Disability LTD
Pension Plan	ODSP
Other: Explain:	WSIB

Please turn over.

REFERRAL FORM ACQUIRED BRAIN INJURY SERVICES

ID Number

Legal Information:		
Has Applicant appointed a Power of Attorney for Property?	Yes	No
Name of POA:	If answer is yes, copy of POA is required	
Photo ID provided? Yes		
Has Applicant appointed a Power of Attorney for Care/SDM?	Yes	No
Name of POA/SDM:	If answer is yes, copy of POA is required	
Photo ID provided? Yes		

Does Applicant have a Public Guardian and Trustee for Property? Yes No		
PGT Name:		
PGT Address:		
Phone Number:	Fax Number:	Email Address:

All Intake forms are available on our website - under ABI Services: www.traverseindependence.ca

If you have questions regarding these forms contact ABI Intake Coordinator for assistance.

Documentation Required with the Referral Form:

Consent to Release Medical Health Information - completed and signed by applicant

Medical Report - completed by a Physician or Nurse Practitioner

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.

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 documentation to:

ABI Intake Coordinator - Traverse Independence
1 -1382 Weber Street East, Kitchener, Ont. N2A 1C4
Phone: 519-741-5845, Ext. 2507 - Fax: 1-519-741-8731 (use prefix 1 also for a local fax)
Email: ABIRef@travind.ca