



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: ABlref@travind.ca

SIMPLE REFERRAL FORM

ABI in the Streets, Mainstream Outreach, Day Program, Intensive Case Coordination, Goal Acquisition Program

APPLICANT INFORMATION

Last Name:

First Name:

Preferred Name:

HOUSING STATUS

- Permanent Housing
- Hospital - Acute
- Rehab. Facility
- Precariously Housed
- Hospital - ALC
- Long term care facility
- Community Rehab.
- 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 Scheduled Programs

Yes

No

For Administration only: Date & ID:

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

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:

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 on:

Or verbal consent received by:

On date (mm/dd/yyyy)

translated the information on this form and verified the clients responses.

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

HELPS - TRAUMATIC BRAIN INJURY (TBI) SCREENING TOOL

Participant (Name / Age): _____

Agency / Screener's Information: _____

Purpose: The following assessment is designed to screen for **possible** occurrences of TBI, which can aid the participant and agency/screener in determining if a medical referral is needed.

H Have you ever **Hit your Head** or been **Hit on the Head**? Yes No

Note: Prompt the participant to think about 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 **Emergency 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 **Lose 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 **Problems** in your daily life since you hit your head? Yes No

Note: Ask the participant 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.

- | | |
|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> difficulty reading, writing, calculating |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> poor problem solving |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> difficulty performing your job/school work |
| <input type="checkbox"/> depression | <input type="checkbox"/> change in relationships with others |
| <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> poor judgment (being fired from job, arrests, fights) |
| <input type="checkbox"/> difficulty remembering | |

S Any significant **Sicknesses**? Yes No

Note: A TBI 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 by a medical professional.
 - **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.
 - If the participant is concerned about their results or would like more information, please talk to your health care provider or call the Brain Injury Alliance of Washington at 1-877-982-4292.
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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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