Hamilton Health Sciences

Acquired Brain Injury Program (ABIP) – Outpatient Referral

Regional Rehabilitation Centre - 300 Wellington St. N Hamilton, ON - L8L 0A4
Phone - 905.521.2100 40807 Fax - 905.521.2359

Referral Date (year/month/day)	Current Location: ☐ Home ☐ Hospital ______ ☐ Other (specify) ______

PATIENT'S PERSONAL INFORMATION

Last Name:	First Name: ☐ Male ☐ Female

Birth Date (year/month/day)	Age	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address – Street (include apartment number if applicable)	City	Province	Postal Code

Telephone (Home)	Telephone (Other)	Health Insurance Number	Version Code (if applicable)

Speaks, Understands English: ☐ Yes ☐ No - Interpreter Needed (language) ______

Responsible for Payment:
☐ OHIP ☐ Auto Insurance ☐ Private Insurer ☐ WSIB ☐ Other ______

POWER OF ATTORNEY	***Personal Care***	Name ______ Telephone ______	***Financial Care***	Name ______ Telephone ______

SUBSTITUTE DECISION MAKER	Name ______ Address ______	Telephone ______ Relationship to Patient ______
NEXT OF KIN / EMERGENCY CONTACT	Name ______ Address ______	Telephone ______ Relationship to Patient ______
FAMILY PHYSICIAN	Name ______ Address ______	Telephone ______ Fax ______
REFERRAL CONTACT	Organization ______ Contact Name / Position ______	Telephone ______ Fax ______

Professionals / Agencies Involved: (e.g. Homecare, Private Rehabilitation Company, Lawyer, etc.)

MEDICAL INFORMATION

Date of Injury / Onset: (year/month/day) ______ ☐ Traumatic ☐ Non-Traumatic GCS Score ______

NATURE OF INJURY: ☐ Anoxic ☐ Encephalitis / Meningitis ☐ Aneurysm ☐ CVA ☐ Struck Head
☐ Fall ☐ Assault ☐ Attempted Suicide ☐ Overdose ☐ MVA ☐ Sports Injury
☐ Tumour ☐ Toxic Exposure ☐ Seizure Disorder ☐ Other ______

Last Name ______________ First Name ______________

Date of Birth ______________ Age ______ HIN # ______________ Expiry Date ______________

MEDICAL INFORMATION – Continued

SUBSTANCE ABUSE HISTORY

ALCOHOL	☐ Currently Present	**DRUGS**	☐ Currently Present
☐ Pre-Injury	☐ Post Injury	☐ Pre-Injury	☐ Post Injury
☐ Diagnosed ☐ Treated	☐ Diagnosed ☐ Treated	☐ Diagnosed ☐ Treated	☐ Diagnosed ☐ Treated
Treated (location)	Treated (location)	Treated (location)	Treated (location)
Rehab (location)	Rehab (location)	Rehab (location)	Rehab (location)

Primary Diagnosis: (relevant to referral) ______________

Medical Surgical History: (relevant to referral) ______________

Relevant Mental Health History: ☐ No ☐ Yes → (describe history, current status including suicidal risk and psychiatric involvement)

Seizures: ☐ No ☐ Yes → (specify) ______________

Allergies: ☐ No ☐ Yes → (list) ______________

☐ Allergy List Complete **or** ☐ Incomplete → Separate Sheet Faxed

CURRENT MEDICATIONS: Include prescription and non prescription medications including:

- oral meds / liquids
- inhalers
- injectables
- "tube" feeds
- patches
- eye / ear drops
- nasal mists
- vitamins / supplements / diet pills
- herbal / natural products
- creams / ointments

Medication (general name preferred)	**Dose** (include units)	**Route**	**Frequency** (note if prn)	**Prescribed By**

Medication List Complete: ☐ Yes ☐ No → Additional List Faxed with Referral

Last Name ______________________ First Name ______________________

Date of Birth ____________ Age ______ HIN # ______________________ Expiry Date ____________

ISSUES IDENTIFIED – (Identify all applicable)

MEDICAL ISSUES ☐ None Identified

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BEHAVIOURAL ISSUES ☐ Wandering ☐ Verbal Aggression ☐ Physical Aggression ☐ None Identified

☐ Inappropriate Sexual Behavior ☐ Self Abuse ☐ Other ______________

Comments ____

COGNITIVE ISSUES ☐ Orientation ☐ Participation ☐ Judgment ☐ None Identified

☐ Carryover / New Learning ☐ Frustration Tolerance ☐ Other ______________

Comments ____

RELEVANT REPORTS ATTACHED: ☐ CT / MRI of Head ☐ Consultation Note ☐ Emergency/Operative Notes

☐ Social Work ☐ Occupational Therapy ☐ Physiotherapy ☐ Other ______________

OUTPATIENT REHABILITATION SERVICE NEEDS

☐ Physiatry ☐ Outreach ☐ Psychiatry ☐ Neuropsychological Assessment ☐ Social Work

COMMUNITY RE-INTEGRATION ISSUES IDENTIFIED ☐ None Identified

☐ Day Program ☐ Support Group ☐ Housing ☐ Work ☐ School ☐ Other ______________

Comments ____

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CONSENT TO DISCLOSE PERSONAL INFORMATION TO HAMILTON HEALTH SCIENCES

Patient's Printed Name ______________________ ______________

Date (year / month / day)

Patient's Signature ______________________

If Substitute Decision Maker: Complete the following

Printed Name ______________________ Signature ______________________

Address ______________________________ Phone Number ______________

Relationship to Patient ______________________ Date (year/month/day) ______________

REFERRING PHYSICIAN

Printed Name ______________________ Signature ______________________

Address ____

Billing Number ______________ Phone ______________ Fax ______________

FAX Completed Referral and any additional documentation to: 905-521-2359