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 ext. 40807 Fax - 905.521.2359

If the patient is 0 – 1 year post injury with a CONCUSSION, DO NOT USE THIS FORM.
Complete the Integrated Adult Concussion Clinic referral form.
Please contact the Integrated Adult Concussion Clinic at 905-521-2100 ext. 40866 for a copy.

TO REQUEST ACCESS TO CONNECT HAMILTON AND BICR ST. PAUL'S PLEASE COMPLETE THIS FORM. PLEASE CHECK BOX FOR SERVICE YOU WOULD LIKE TO ACCESS

☐ **CONNECT Communities Hamilton Transitional Living Program**

☐ **BICR St. Paul's Transitional Living Program**

Instructions to Complete ABI Outpatient Referral Form

All referral forms are available on the Hamilton Health Sciences Acquired Brain Injury Program website www.hamiltonhealthsciences.ca - Acquired Brain Injury Program

If you require assistance, please contact the intake office (905)521-2100 Ext 40807

For your referral to be processed:

- ☐ Complete the referral in full and ensure both patient and referring physician sign the consent portion on page 3
- ☐ Verbal Consent from your patient is also acceptable but you must ensure that you speak to your patient about the referral.
- ☐ Include a detailed description of the brain injury
- ☐ Include relevant diagnostic imaging (CT; MRI; EEG etc.)
- ☐ Select Outpatient Rehabilitation Services Needed based on patient funding.

Additional information that would be helpful:

- ☐ Relevant medical reports
- ☐ Recent rehabilitation reports (i.e.: PT, OT, SLP, Psychology etc.)
- ☐ Mental health/psychiatric reports if applicable
- ☐ Brief description of the current issues

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

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Regional Rehabilitation Centre - 300 Wellington St. N Hamilton, ON - L8L 0A4
Phone - 905.521.2100 40807 Fax - 905.521.2359 **Revised 2018**

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

PATIENT'S PERSONAL INFORMATION

Last Name:	First Name:	Gender:
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	

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

Responsible for Payment:
☐ OHIP ☐ Auto Insurance ☐ Private Insurance ☐ WSIB ☐ Extended Health ☐ Other _____

PERSON TO CONTACT
Name _____ Telephone _____
Address _____ Relationship To Patient _____

FAMILY PHYSICIAN
Name _____ Telephone _____
Address _____ Fax _____

REFERRAL CONTACT
Organization _____ Telephone _____
Contact Name / Position _____ Fax _____

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

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICAL INFORMATION

DATE OF INJURY: (year/month/day) _____

CAUSE OF INJURY: ☐ Anoxic ☐ Encephalitis / Meningitis ☐ Aneurysm ☐ CVA ☐ Struck Head
☐ Fall ☐ Assault ☐ Attempted Suicide ☐ Overdose ☐ MVA ☐ Sports Injury
☐ Tumor ☐ Concussion (Post 1yr) ☐ Other _____

Last Name _____ First Name _____

Date of Birth _____ Age _____ HIN # _____ Expiry Date _____

MEDICAL INFORMATION – *Continued*

RELEVANT MEDICAL/SURGICAL HISTORY:

☐ Prior head injuries – *indicate how many* _____

☐ Substance Abuse: Past _____ Present _____ ☐ Neurodevelopmental problems (ex. ADHD, Learning Disability)

☐ Surgery: Specify _____

☐ History of headache/migraine disorder ☐ Sleep Disorder (ex. Sleep apnea) ☐ Seizure Disorder

☐ Chronic Pain ☐ Other relevant medical information: _____

_____

CURRENT MEDICAL ISSUES: ☐ Headaches ☐ Light Sensitivity ☐ Noise Sensitivity ☐ Dizziness ☐ Sleep problems ☐ Mobility ☐ Other _____

Comments _____

COGNITIVE ISSUES: ☐ Orientation ☐ Participation ☐ Judgment ☐ Carryover / New Learning ☐ Mental Fatigue ☐ Memory ☐ Other _____

Comments: _____

BEHAVIOURAL ISSUES ☐ Wandering ☐ Verbal Aggression ☐ Physical Aggression ☐ Frustration Tolerance ☐ Inappropriate Sexual Behavior ☐ Self Abuse ☐ Other _____

Comments: _____

MENTAL HEALTH DIAGNOSIS: ☐ Past ☐ Present Please Describe:

RELEVANT REPORTS ATTACHED: ☐ Current Medication List ☐ CT/MRI ☐ Emergency/Operative Notes ☐ Social Work ☐ Occupational Therapy ☐ Physiotherapy ☐ Speech Therapy ☐ Mental Health ☐ Other _____

OUTPATIENT REHABILITATION SERVICE NEEDS

OHIP FUNDED:

☐ **Outpatient Medical Clinic –** Specialty medical clinic overseen by Physiatrist and/or Neurologist. Patients will be seen to address symptoms related to the identified head injury (ex. Headaches, dizziness, sleep problems etc.)

☐ **Outreach Service –** A time-limited service provided by a Rehabilitation Therapist, a non-regulated health professional with expertise in ABI recovery. The Rehabilitation Therapist works in the home and community of patients who live within **an hour radius** of Hamilton. The goal of this service is to facilitate a return to community living focusing on the patient's social, vocational, recreational, and academic pursuits while managing their new brain injury.

☐ **Cognitive Behaviour Therapy Group** - The CBT group is a 10 week program teaching the basics of this therapy approach to individuals who have had an ABI and struggle with mood. It is designed to be generic in nature and education is related to mood/anxiety only. The group is not intended to be a support group but one to help with skill building.

☐ **ABI Education Group** - A 9 week series of ABI Psychoeducational topics providing current information and effective coping strategies for some of the most common challenges faced by ABI survivors. The small group format offers peer support through group discussion and sharing.

Last Name _____ First Name _____

Date of Birth _____ Age _____ HIN # _____ Expiry Date _____

ABI COMMUNITY SERVICES **** FEE FOR SERVICE PROGRAM****

*** Funding source:** ☐ MVA ☐ WSIB ☐ Health Benefits ☐ Other _____

ABI Community Services is a community-based fee-for-service program within Hamilton Health Sciences Acquired Brain Injury Program. It consists of the following services:

☐ **Neuropsychological Assessment**- In depth assessment of cognitive and psychological issues. Assessment includes interview, testing, feedback session and formal report with recommendations for managing current cognitive and psychological impairments.

☐ **Counselling**- Group therapy treatment for individuals struggling with their psychological/emotional functioning following an acquired brain injury.

☐ **Rehabilitation Therapy**- An Advanced Rehabilitation Therapist (ART), a non-regulated health professional with expertise in ABI recovery, will work with the client and their community care team to develop goals to return to work school or leisure activities after sustaining an acquired brain injury. The ART can work independently with the client or as a part of a team of regulated health professionals i.e. occupational therapy, physio therapy or speech language pathology.

Please include any additional relevant information pertaining to this referral:

CONSENT TO DISCLOSE PERSONAL INFORMATION TO HAMILTON HEALTH SCIENCES AND ABI SYSTEM NAVIGATOR IF NECESSARY.

Patient's Printed Name: _____ Date (year / month / day) _____

Patient's Signature: _____ **OR** ☐ Verbal Consent Obtained

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 _____

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