



Regional Community Brain Injury Services

Referral Form

Note: Prior to completing referral, please refer to attached eligibility criteria.

For further information or help to complete this form contact:

in Kingston

Regional Community Brain Injury Services
303 Bagot Street, LaSalle Mews, Suite 401
Kingston, Ontario K7K 5W7

Phone: (613) 547-6969
Fax: (613) 547-6472

in Brockville

Regional Community Brain Injury Services
The Brockville Centre
125 Stewart Boulevard, Suite 227
Brockville, Ontario K6V 4W4

Phone: (613) 342-1613
Fax: (613) 342-1055

in Belleville

Regional Community Brain Injury Services
Quinte Mall Office Tower
100 Bell Blvd., Suite 335
Belleville, Ontario K8P 4Y7

Phone (613) 968-8888
Fax: (613) 968-9220

Client Name: _____			
Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/>			
Status: Divorced <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>			
Address: _____ _____ _____			
Postal Code: _____	County:	KFLA	<input type="checkbox"/>
		HPE	<input type="checkbox"/>
Telephone: _____		LLG	<input type="checkbox"/>
		OTHER	<input type="checkbox"/>
Date of Birth: _____			
(e.g. 01 January 1986)	Health Card Number and Version Code: _____		
Reason for Referral: How can we help? _____ _____ _____			
Is client legally competent with respect to personal care?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is client legally competent with respect to finances?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Contact information for substitute decision maker (if applicable) Name: _____			
Address: _____		Telephone Number: _____	

❖ Please note that the referral cannot be processed without medical documentation of acquired brain injury. Referral must include information regarding loss of consciousness: GCS, CT/MRI/other imaging results and hospital discharge summary.

Brain Injury: Date: _____ Cause: _____

Severity: Severe (loss of consciousness more than 24 hours)
 Moderate (loss of consciousness 20 minutes – 24 hours)
 Mild (loss of consciousness less than 20 minutes). Documentation must include positive CT/MRI findings or evidence of multiple mild injuries.

Above Medical Reports Attached? YES Reports will be forwarded by:

Living Situation: Alone With Family With Spouse
Other Specify: _____

Treatment Address (if different than address given): _____

Person to Contact in Case of Emergency: _____

Phone Number: _____ Address: _____

Services received/requested from others at this time:

Funding: No Yes WSIB Motor Vehicle Insurance

If yes, specify: Name of Company: _____

Name/Contact Person: _____

Address: _____

Telephone: _____ Identification/Claim No.: _____

Family doctor: _____ Telephone: _____

Address: _____

Referred by: _____

Name: _____

Address: _____

Telephone: _____ Agency/Relationship: _____

Signature: _____ Date: _____

(eg 01 January 2005)

Client or Substitute Decision Maker has provided informed consent to make referral: Yes No