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. ☐ **Mrs.** ☐ **Ms** ☐ **Miss** ☐

Status: Divorced ☐ **Married** ☐ **Partner** ☐ **Single** ☐ **Widowed** ☐ **Separated** ☐

Address: ______________________________

____

____

Postal Code: ______________________

Telephone: ______________________

County:

KFLA ☐
HPE ☐
LLG ☐
OTHER ☐

Date of Birth: ______________________
(e.g. 01 January 1986)

Health Card Number and Version Code: ______________________

Reason for Referral: How can we help?

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____

____

Is client legally capable with respect to personal care? **Yes** ☐ **No** ☐

Is client legally capable with respect to finances? **Yes** ☐ **No** ☐

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.**

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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 ☐