



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

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

Community Brain Injury Services
23 Abbott St.
Brockville, Ontario K6V 4A5

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

in Belleville

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

Client/Substitute Decision Maker Name: _____ **Signature** _____

Client Name: _____

Male Female

Status: Divorced Married Partner Single Widowed Separated

Address: _____

Postal Code: _____ **County:** **KFLA**
HPE
LLG
OTHER

Telephone: _____

Date of Birth: _____
(e.g. 01 January 1986) **Health Card Number and Version Code:** _____

Reason for Referral: How can we help? _____

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:** _____

CBIS provides services to adults who have sustained a moderate to severe brain injury. In order to determine if a person meets our criteria for service, we review information regarding GCS, loss of consciousness, and CT/MR/other imaging results. Forwarding records that report on one or more of these areas, with the referral, will allow us to process your request for service more efficiently.

Brain Injury: Date: _____ Cause: _____

Above Medical Reports Attached? YES No Reports will be forwarded by:

Living Situation: Alone With Family Name: _____

With Spouse Name: _____ Other Specify: _____

Treatment Address (if different than address given): _____

Person : _____

Phone Number: _____ Address: _____

Other service providers 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)