Providence Care

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
LaSalle Mews
303 Bagot Street, Suite 401
Kingston, ON 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: _____

Permission to leave voicemail Yes ☐ No ☐

Date of Birth: _____ **Health Card Number:** _____

(e.g. 01 January 1986) **Version Code & Expiry Date:** _____

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 ☐ With Spouse ☐ Other ☐Specify: _____

Name: _____

Emergency Contact: Name: _____ Relationship: _____

Address: _____

Telephone: _____

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)

303 BAGOT ST, LaSALLE MEWS, STE 401, KINGSTON, ONTARIO K7K 5W7 (613) 547-6969 FAX 547-6472