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
☐ 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 (ie: PT, OT, SLP, Psychology etc)
☐ Mental health/psychiatric reports if applicable
☐ Brief description of the current issues
**Acquired Brain Injury Program (ABIP) Outpatient Referral**

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

### PATIENT’S PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Header</th>
<th>Field</th>
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<tbody>
<tr>
<td>Referral Date</td>
<td>Current Location: □ Home □ Hospital □ Other (specify)</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Birth Date (year/month/day)</td>
<td>Age</td>
</tr>
<tr>
<td>Address – Street (include apartment number if applicable)</td>
<td>City</td>
</tr>
<tr>
<td>Telephone (Home)</td>
<td>Telephone (Other)</td>
</tr>
</tbody>
</table>

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

### RESPONSIBLE FOR PAYMENT:

- □ OHIP □ Auto Insurance □ Private Insurance □ WSIB □ Extended Health □ Other

### PERSON TO CONTACT

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
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<tbody>
<tr>
<td>Address</td>
<td>Relationship to Patient</td>
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### FAMILY PHYSICIAN

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
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<tr>
<td>Address</td>
<td>Fax</td>
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### REFERRAL CONTACT

<table>
<thead>
<tr>
<th>Organization</th>
<th>Telephone</th>
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<tbody>
<tr>
<td>Contact Name / Position</td>
<td>Fax</td>
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</tbody>
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### Professionals / Agencies Involved: (e.g. Physicians, Specialists, Homecare, Private Rehabilitation, Lawyer, etc.)

1.  
2.  
3.  
4.  
5.  
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
MEDICAL INFORMATION – Continued

RELEVANT MEDICAL/SURGICAL HISTORY:
- Prior head injuries – indicate how many
- Substance Abuse: Past Present
- Surgery: Specify
- Neurodevelopmental problems (ex. ADHD, Learning Disability)
- 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 Psychiatrist and/or Neurologist. Patients will be seen to address symptoms related to the identified head injury (ex. Headaches, dizziness, sleep problems etc.)

- Neuropsychiatry - ** Single consult assessment ** to provide recommendations to the patient and Most Responsible Physician regarding post-traumatic changes in mood such as Depression, Anxiety, PTSD, behavior problems etc.

- Outreach Service – A time-limited service overseen by a Rehabilitation Therapist that works in the home and community of patients, within an hour radius of Hamilton. The aim of this service is to facilitate a return to community living within the patient’s social, vocational, recreational, and academic goal areas.

- 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.

- 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.
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.
- **Rehabilitation Therapy** – Rehab professionals implement individualized treatment plans developed to focus on practical skills for functional daily living in collaboration with other professionals involved.
- **Psychology Counseling** – Individual counseling for treatment of psychological and behavioural issues.

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: ___________________________

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: ___________________________

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