

If the patient is 0 – 1 year post injury with a CONCUSSION, DO NOT USE THIS FORM.

Complete the Integrated Adult Concussion Clinic referral form.

Please contact the Integrated Adult Concussion Clinic at 905-521-2100 ext. 40866 for a copy.

TO REQUEST ACCESS TO CONNECT HAMILTON AND BICR ST. PAUL'S PLEASE COMPLETE THIS FORM. PLEASE CHECK BOX FOR SERVICE YOU WOULD LIKE TO ACCESS

CONNECT HAMILTON

BICR ST. PAUL'S TRANSITIONAL LIVING

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

Referral Date	Current Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital _____ <input type="checkbox"/> Other (specify) _____
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PATIENT'S PERSONAL INFORMATION

Last Name:		First Name:		Gender:	
Birth Date (year/month/day)		Age		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Address – Street (include apartment number if applicable)			City		Province
					Postal Code
Telephone (Home)		Telephone (Other)		Health Insurance Number	
				Version Code	
Speaks, Understands English: <input type="checkbox"/> Yes <input type="checkbox"/> No - Interpreter Needed (language) _____					
Responsible for Payment: <input type="checkbox"/> OHIP <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Private Insurance <input type="checkbox"/> WSIB <input type="checkbox"/> Extended Health <input type="checkbox"/> Other _____					

PERSON TO CONTACT	Name _____	Telephone _____
	Address _____	Relationship to Patient _____

FAMILY PHYSICIAN	Name _____	Telephone _____
	Address _____	Fax _____

REFERRAL CONTACT	Organization _____	Telephone _____
	Contact Name / Position _____	Fax _____

Professionals / Agencies Involved: (e.g. Physicians ,Specialists ,Homecare, Private Rehabilitation, Lawyer, etc.)

1.	4.
2.	5.
3.	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 _____



Last Name _____ First Name _____

Date of Birth _____ Age _____ HIN # _____ Expiry Date _____

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.



Fax Referral Date: (yyyy/mm/dd) _____ (ABIP Outpatient Referral – 712723 – 2018-05)

Last Name _____ First Name _____

Date of Birth _____ Age _____ HIN # _____ Expiry Date _____

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



712723 (2018-05)
Consults – Referrals