Traverse Independence
1-1382 Weber Street East – Kitchener, ON N2A 1C2
Phone 519-741-5845 – Fax 519-741-8731

Referral Type	☐ Internal	☐ External
Date Referral Form Completed (dd/mm/yyyy)		

REFERRAL FORM – BRAIN INJURY SERVICES ID

ELIGIBILITY CRITERIA

- Have a diagnosis of an acquired brain injury as confirmed by a physician.
- Have clear rehabilitative goals that can be achieved during length of time in program.
- Demonstrate capacity for functional rehabilitation.
- Be an active participant in achieving mutually agreed upon goals.
- Be medically stable.
- Be safe should they leave the transitional living setting while in residence.
- Be psychiatrically stable such that it will be not interfere with participation in rehabilitation.
- Be sixteen year of age or older.
- Not be diagnosed with a developmental disability, in-utero/at birth ABI or be under the age of 16.
- Be willing to relocate to Kitchener or Fergus
- Be insured by OHIP.

NOT APPROPRIATE

- The Transitional Program does not offer permanent housing. The intended length of stay is up to 12 months.
- Participants cannot exhibit behaviours that may put themselves, other participants or heath care professionals in danger or at risk.
- Be free of psychiatric or behavioural symptoms of a disorder that would preclude the participant from being able to participate in mutually agreed upon goals.

DOCUMENTATION REQUIRED WITH REFERRAL FORM

☐ Consent to Release Medical Health Information – completed and signed by applicant

☐ Medical Report – completed by a physician or nurse practitioner

☐ Pertinent medical information completed by current (or past – if relevant) service provider involved in applicant's care, such as OT, PT, Neurologist, etc. This information is required in referrals done by hospital, LHIN, Long Term Care facilities, mental health services, insurance, etc.

☐ Copy of Power of Attorney, if applicable

☐ Copy of photo identification card, for instance driver's license, passport, or health card

Please send completed forms and pertinent information to:

ABI Intake Coordinator – Traverse Independence
1-1382 Weber Street East, Kitchener, ON N2A 1C4
Phone 519-741-5845 ext. 2507 – Fax 519-741-8731 – Email ABIRef@travind.ca

APPLICANT INFORMATION

Last Name | First Name

Preferred Name

Address (St + Apt #)

City/Province | Postal Code

Phone Number | Cell Number

Email Address

Health Card Number

Date of Birth | Gender

Preferred Pronouns

Preferred Communication Language

☐ English ☐ French ☐ Other (Specify)

WHO SHOULD BE CONTACTED REGARDING THIS INTAKE?

☐ Applicant

☐ Family/Support Contact

☐ Referral Person

☐ Other (Specify)

Considerations when contacting this applicant.

CURRENT LOCATION

☐ Home ☐ Hospital - Acute ☐ Hospital - ALC

☐ Long Term Care Facility ☐ Rehab Hospital

☐ Other

FAMILY/SUPPORT CONTACT INFORMATION

Last Name | First Name

Relationship

Address (St + Apt #)

City/Province | Postal Code

Home Phone Number | Cell Number

Email Address

REFERRAL PERSON CONTACT INFORMATION

Last Name First Name

Organization

Address (St + Apt #)

City/Province

Phone Number Fax Number

Email Address

MEDICAL INFORMATION

Date of Brain Injury

Seizure History ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Previous medical or rehabilitation facilities [Facility Name and Length of stay]

_____

Please attached medical documentation regarding ABI (Phycisian notes confirming diagnosis, MRI and CT Scan findings, hospital admission and discharge notes)

Origin of Acquired Brain Injury – please check off and/or explain

☐ Motor Vehicle Collisiion ☐ Non-Traumatic Injury ☐ Traumatic Injury

☐ Brain Tumour ☐ Stroke ☐ Concussion

☐ Other (Specify)

Provide a brief explanation.

ISSUES/CONCERNS IDENTIFIED

☐Orientation	☐Motivation/ Initiation	☐Impulsivity	☐Organization/Planning
☐Verbal Aggression	☐Memory	☐Pain	☐Irritability
☐Nervousness	☐Fatigue	☐Sadness	☐Concentration
☐Insight	☐Physical Aggression	☐Self Harm	☐Perseveration
☐Communication	☐Other		

Current ABI Supports: _____

CAPACITY FOR REHAB

- Has realistic life skill goals.
- Willingness to/or demonstrate daily motivation to participate and/or learn daily life tasks.
- Willingness to work through new compensatory strategies.

REHABILITATION GOALS (have clear goals that can be achieved during time in the program)

☐ Schedule development	☐Housekeeping	☐Personal Hygiene	☐Sleep Hygiene
☐Kitchen Safety/Meal Planning	☐ Grocery Shopping	☐Volunteering	☐School Involvement
☐ Vocational	☐ Transportation Training	☐Community Integration	☐Social Skills
☐Social/ Group Interactions	☐ Leisure Activities	☐Communication Skills	☐Cognitive Skills
☐ Personal Safety	☐ Managing Finances [budgeting/banking]	☐Learning to self-direct	☐Behaviour Management
☐ Physical Fitness	☐Personal Safety in the community	☐ Medication Management	☐ Organizational Strategies

CONCURRENT Health Information/Diagnoses/Mental Health Concerns [Please indicate any other disabilities or medical conditions that may affect delivery of your services] (i.e., diabetes, difficulty swallowing, allergies, communicable diseases, special diet, heart disease)

CURRENT PROFESSIONAL SERVICES

Service	Agency/Provide Name	Number of visits per week / month	Duration of each visit
Homemaking			
Occupational Therapy			
Nursing			
Attendant Services			
Physicians (psychologists, psychiatrists, neurologist, etc.)			
Other *(specify)*			
Other *(specify)*			

Do you currently have a Service Animal or Pet?

☐Service Animal ☐Pet

Information (written and demonstrated) regarding the specific types of intervention the services animal provides and for what purpose:

Are you currently receiving mental health supports?

☐ Yes ☐ No

If yes, what is the name of your assigned worker?

Do we have consent to contact this organization?

☐ Yes ☐ No

Are you currently using substances?

☐ Yes ☐ No

Are you connected to addiction supports?

☐ Yes ☐ No

If no, would you be willing to work with addiction supports?

☐ Yes ☐ No

Do we have consent to contact the organization that provides these supports?

☐ Yes ☐ No

If yes, what is the name of the organization and your assigned worker?

Are you currently experiencing homelessness or precarious housing?

☐ Yes ☐ No

Describe

Have you experienced Intimate partner violence?

☐ Yes ☐ No

Describe

What will your living situation be after you are discharged from the Transitional Program?

Previous or current involvement with the criminal justice system. If yes, please provide detailed information.

☐ Yes ☐ No

Describe

PHYSICIAN CONTACT INFORMATION

Primary Care Physician			
Address			
City/Province		Postal Code	
Phone Number		Fax Number	
Name of Specialist			
Specialist's Address			
City/Province		Postal Code	

INCOME INFORMATION

Current Source of Income – please check.

☐ Auto Insurance	☐ Annuity	☐ Tort Action
☐ Pension Plan	☐ CPP (D)	☐ Disability STD
☐ Disability LTD	☐ ODSP	☐ WSIB
☐ Other (Specify)		

LEGAL INFORMATION

Power of Attorney (POA) for Property

Has Applicant appointed a POA for Property?

☐ Yes ☐ No ☐ POA is not needed

If the answer is yes, a copy of the POA is required.

Name of POA

☐ Yes, photo ID provided

Type of ID

Power of Attorney (POA) for Care/SDM

Has Applicant appointed a POA for Care/SDM?

☐ Yes ☐ No ☐ POA is not needed

If the answer is yes, a copy of the POA/SDM is required.

Name of POA

☐ Yes, Photo ID was provided

Type of ID

Public Guardian and Trustee for Property (PGT)

Does Applicant have a PGT for Property?

☐ Yes ☐ No

Name of PGT

PGT's Address

City/Province Postal Code

Phone Number Fax Number

Email Address

BEFORE SUBMISSION, PLEASE ENSURE YOU HAVE INCLUDED THE FOLLOWING DOCUMENTS

☐ Referral Form

☐ Medical Report - completed by a physician or nurse practitioner

☐ Current Medication

☐ Consent to Release Medical Health information - completed and signed by applicant

☐ Medical Information from Service Providers

☐ Copy of Power of Attorney - if applicable

☐ Pertinent medical information completed by current (or past - if relevant) service provider involved in applicant's care, such as OT, PT, Neurologist, etc. This information is required in referrals done by Hospital, CCAC, Long, Terms Care Facilities, Mental Health Services, Insurance, etc.

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☐ New Applicant ☐ Former Traverse Client

Traverse Independence is a personal health information custodian under the Ontario Personal Health Information Protection Act, 2004. We are committed to protecting the privacy, confidentiality and security of all personal information entrusted to us.

All our intake forms are available on our website www.traverseindependence.ca under ABI Services. If you have questions regarding these forms, contact the ABI Intake Coordinator for assistance. Phone 519- 741-5845 ext. 2507 or email ABIRef@travind.ca.