



# Application For Service

225 King William St., Suite 508  
 Hamilton, ON L8R 1B1  
 Tel: 905-523-8852 Fax: 905-523-8211  
 Email: [info@braininjuryservices.com](mailto:info@braininjuryservices.com)  
 Web: [www.step-up-abi.com](http://www.step-up-abi.com)

Client Name: \_\_\_\_\_  Male  Female  
 (Last Name, First Name)

Health Card #: \_\_\_\_\_ Version#: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 year month day year month day

## PERSONAL INFORMATION

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Check One:  Single  Married  Divorced

Current Living Situation:  alone  with others (specify) \_\_\_\_\_

### Accommodation:

- house  group home  apartment building  supportive housing  rooming house  
 long term care facility  hospital  other \_\_\_\_\_

Citizenship:  Canadian  Permanent Resident  Other

Are you a resident of Ontario?  Yes  No If yes, how long? \_\_\_\_\_

Language Spoken: \_\_\_\_\_ Interpreter Required:  Yes  No

First Nation Band Affiliation: \_\_\_\_\_

Status Number with Dept. of Indian Affairs: \_\_\_\_\_

## BRAIN INJURY INFORMATION

Date of Injury: \_\_\_\_\_

Cause of Injury: (e.g., anoxia, assault, motor vehicle accident, fall, etc.)

Ontario Association of Community-Based Boards for Acquired Brain Injury Services (OACBABIS)

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the client or substitute decision maker. Revised November 14, 2007.

**PERSONAL SUPPORT NETWORK /EMERGENCY CONTACTS**

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Other Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**REFERRING AGENT (who is making the request):**

Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Agency \_\_\_\_\_ Email: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Person Yes No

**TYPE OF SERVICE REQUESTED**

Residential  Day Services  Outreach Services  Other

**TREATMENT HISTORY INCLUDING CURRENT SERVICES**

Program/Facility/Hospital	Dates Involved (year/month/day)	Contact Name and Phone Number

**LIST OF SERVICES YOU HAVE APPLIED FOR FROM OTHER AGENCIES**  
(e.g., Vocation Rehabilitation, Addiction Services)

Name of Facility / Program	Contact Person	Address, phone number	Status of Application

Please note that medical, attendant care, rehabilitation and vocational reports are required: Neurosurgery, Neuropsychology, Speech Therapy, Physiotherapy, Occupational Therapy, Social Work, Psychology, Psychiatry, Assessment and Discharge Summaries. If you have copies of these reports please attach to the application.

**PERSONAL INFORMATION**

Seizures  No  Yes  
 If yes, describe: \_\_\_\_\_

Wheelchair  No  Yes  Manual  Motorized  
 Transfers  Yes  No  
 If yes, describe: \_\_\_\_\_

Assistive Devices  No  Yes  
 If yes state what is needed: \_\_\_\_\_

Attendant Care  No  Yes  
 If yes, describe: \_\_\_\_\_

Supervision or assistance with walking  No  Yes  
 If yes, does it apply to:  level surfaces  stairs or  both

Communication Issues:  No  Yes  
 If yes, describe: \_\_\_\_\_

Other Physical Conditions (allergies, heart conditions, diet restrictions, etc)  No  Yes  
 If yes, describe: \_\_\_\_\_

Pre-Injury History of Substance Abuse:  No  Yes  history not available  
 Current Substance Abuse:  No  Yes  not known  
 Substance Abuse Treatment Recommended:  No  Yes  
 Previous Psychiatric History:  No  Yes  
 Describe: \_\_\_\_\_

Current Psychiatric Status: \_\_\_\_\_  
 Psychiatric Consult Notes:  included  report to follow  not available

Education: \_\_\_\_\_ Highest \_\_\_\_\_ grade/level \_\_\_\_\_ attained:  
 If \_\_\_\_\_ in \_\_\_\_\_ school, \_\_\_\_\_ name \_\_\_\_\_ of \_\_\_\_\_ school:

Name of Last Employer: \_\_\_\_\_  
 Position: \_\_\_\_\_ How long were you in this position? \_\_\_\_\_

<b>FINANCIAL INFORMATION</b>	
Check Source Of Income:	
<input type="checkbox"/> Ontario Disability Support Program (ODSP)	<input type="checkbox"/> Ontario Works (OW)
<input type="checkbox"/> Old Age Security (OAS)	<input type="checkbox"/> Canadian Pension Plan (C.P.P.)
<input type="checkbox"/> Workplace Safety Insurance Board (W.S.I.B.)	<input type="checkbox"/> Long Term Disability (private)
<input type="checkbox"/> Lawyer's Name: _____	
Company: _____	Phone: _____
<input type="checkbox"/> Insurance Adjuster Name: _____	
Company: _____	Phone: _____
<input type="checkbox"/> Rehabilitation Case Manager Name: _____	
Company: _____	Phone: _____
<input type="checkbox"/> Insurance Settlement <input type="checkbox"/> Structured Settlement <input type="checkbox"/> Inheritance <input type="checkbox"/> Part Time Employment <input type="checkbox"/> Full Time Employment <input type="checkbox"/> Income Generating Assets - please describe: _____	
Amount of income per month: _____	
Do you have direct access to your income? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, Name and Phone Number of Substitute Decision Maker/Power of Attorney and attach supporting documentation:	

I, \_\_\_\_\_ certify that the above mentioned information is correct, to the best of my knowledge.

\_\_\_\_\_  
Signed (Applicant or Substitute Decision Maker)      Date

Signed (Applicant or Substitute Decision Maker)		Date	
ONTARIO COMMUNITY BASED NON-PROFIT PROGRAMS FOR ADULTS WHO LIVE WITH THE EFFECTS OF BRAIN INJURY			
Program Name (Check off agencies you have made application to)	Address	Phone Number	Fax Number
<input type="checkbox"/> Acquired Brain Injury Program – The Rehabilitation Centre	125 Scrivens St. Ottawa, ON K2B 6H3	(613) 726-1558	(613) 726-1764
<input type="checkbox"/> Brain Injury Community Re-Entry (Niagara) Inc.	261 Martindale Rd., Units 12 & 13 St. Catharines, ON L2W 1A1	(905) 687-6788 1 800 996-8796	(905) 641-2785
<input type="checkbox"/> Brain Injury Services	225 King William St., Suite 508 Hamilton, ON L8R 1B1	(905) 523-8852	(905) 523-8211
<input type="checkbox"/> Brain Injury Services of Northern Ontario	426 Balmoral St. Thunder Bay, ON P7C 5G8	(807) 623-1188	(807) 623-1201
<input type="checkbox"/> Brain Injury Services of Simcoe Muskoka	560 Bryne Dr. Unit 4 Barrie, ON L4N 9P6	(705) 734-2178 Toll Free #: 877-320-1950	(705) 734-1598
<input type="checkbox"/> Community Head Injury Resource Services of Toronto (CHIRS)	62 Finch Avenue West Toronto, ON M2N 2H4	(416) 240-8000	(416) 240-1149
<input type="checkbox"/> Dale Brain Injury Services Inc.	815 Shellborne St. London, ON N5Z 4Z4	(519) 668-0023	(519) 668-6783
<input type="checkbox"/> Peel Halton Acquired Brain Injury Services (PHABIS)	176 Robert Speck Parkway Mississauga, ON L4Z 3G1	(905) 949-4411	(905) 949-4019
<input type="checkbox"/> Vista Centre	211 Bronson Ave., Ste. 214 Ottawa, ON K1R 6H5	(613) 234-4747	(613) 234-3625



## Brain Injury Services

*Medical Status Form*  
**(Must be completed by a medical doctor)**

\_\_\_\_\_ has applied to Brain Injury Services. In order to approve  
 (Name and date of birth) application, form must be a completed in full.

<b>Physical Status</b>
Does the applicant require a wheelchair YES _____ NO _____ Manual _____ Motorized _____
Does the applicant require other assistive devices? Please state what is needed:
Does the applicant require attendant care? YES _____ NO _____ If yes please explain,
Does the applicant require supervision or assistance with walking? YES _____ NO _____ Does that apply to: _____ level surfaces _____ stairs _____ both
Can applicant transfer independently? YES _____ NO _____ Please describe assistance required:
Are there any communication issues? YES _____ NO _____ Please describe:
Are there any other physical conditions that should be mentioned? (allergies, heart conditions, diet restrictions, etc.) YES _____ NO _____

<b>Medications</b>			
Name of Medication	Dosage	Reason	Side Effects

(Add additional pages if necessary )

Medication Administration: Self \_\_\_\_\_ or Other \_\_\_\_\_, Specify who:

<b>Seizures</b>
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Has applicant experienced a seizure? YES \_\_\_\_\_ NO \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Frequency of seizures: Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Other, please specify \_\_\_\_\_

Are there any interventions, pre or post seizure activity that we need to be aware of? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please specify:

Is the applicant's **PRIMARY** diagnosis an acquired brain injury? YES \_\_\_\_\_ NO \_\_\_\_\_  
If NO, please specify primary diagnosis:

Is the injury progressive or degenerative in nature? YES \_\_\_\_\_ NO \_\_\_\_\_  
Please specify diagnosis:

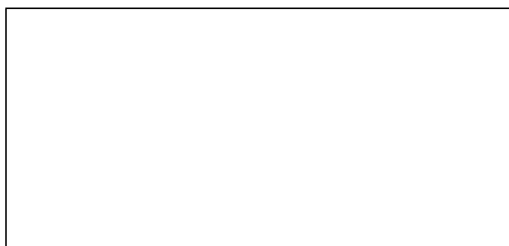
Is there a secondary and/or dual diagnosis? YES \_\_\_\_\_ NO \_\_\_\_\_  
If YES, please specify:

Are there any behavioural concerns: YES \_\_\_\_\_ NO \_\_\_\_\_  
Please explain:

Is there a history of substance abuse? YES \_\_\_\_\_ NO \_\_\_\_\_  
Are there current substance abuse issues? YES \_\_\_\_\_ NO \_\_\_\_\_  
Please specify substance abuse issues:

\_\_\_\_\_  
DATE

Physician's Signature or Stamp:



Please return form to:

Brain Injury Services  
225 King William Street, Suite 508  
Hamilton, ON  
L8R 1B1  
Fax (905) 523-8211