HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

REFERRAL FORM
ACQUIRED BRAIN INJURY PROGRAM
1453 Prince Road, Windsor, Ontario N9C 3Z4
Phone: 519-257-5458 Fax: 519-257-5242

ONLY PHYSICIANS MAY MAKE REFERRALS

DATE OF REFERRAL: _____
(Month) (Day) (Year)

FAX TO: 519-257-5242

CLIENT NAME: _____ D.O.B.: _____
(Last) (First) (Month) (Day) (Year)

Marital Status: ☐ S ☐ M ☐ W ☐ Sep ☐ C/L Sex: ☐ M ☐ F

Address: _____
(Street) (City) (Province) (Postal Code)

Main Telephone: Alternate Telephone:

Language Spoken: ☐ English ☐ French ☐ Other ☐ Specify:

Healthcard # & Ver. Code: Family Physician:

Contact Person for Further Intake: Relationship:

Contact's Telephone: Alternate Telephone:

PHYSICIAN MAKING REFERRAL: Telephone:

Agency: OHIP Billing #

Client / Substitute Decision Maker in Agreement with Referral? ☐ Y ☐ N

DIAGNOSIS:

Date of Injury / Event: _____
(Month) (Day) (Year)

Was the injury / event work-related? ☐ Y ☐ N

Nature / Type of Injury / Event:
☐ MVC ☐ MVC motorcycle ☐ MVC bicycle/pedestrian
☐ Fall ☐ Assault ☐ Sports
☐ Trauma Specify: _____
☐ Non-Trauma Specify _____
☐ Unknown

Is the client aware of deficits or changes which have occurred since the injury? ☐ Y ☐ N

Is the client eligible for MVC insurance? ☐ Y ☐ N

PRIMARY REASON FOR REFERRAL / GOALS: _____

Service Requested:
☐ Consultation ☐ Treatment Planning / Intervention
☐ Neuropsychology ☐ Social Work ☐ Occupational Therapy
☐ Psychiatry **Physician 's signature and OHIP Billing # are required below**
Signature: Billing #:

Do you require a follow-up report? ☐ Y ☐ N

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Client Name: _____

MEDICAL INFORMATION:

Previous Relevant Medical History: _____

_____

Previous History of ABI: ☐ Y ☐ N Describe: _____

Pre-Injury History of Substance Abuse: ☐ Y ☐ N ☐ History Not Available

Status on Admission: _____

Current Substance Abuse: ☐ Y ☐ N ☐ Not Known

Substance Abuse Treatment Recommended: ☐ Y ☐ N

Current Psychiatric Status: _____

_____

Previous Diagnosis of Dementia or Mild Cognitive Impairment: ☐ Y Date: _____ ☐ N

Seizures: ☐ Y Dates: _____ ☐ N

SERVICE INFORMATION: **Consult Notes and Relevant Reports are Required**

Consult Notes and Reports are Attached:: ☐ Y

TREATMENT HISTORY INCLUDING CURRENT SERVICES:

Program / Facility / Physician / Therapies	Dates Involved (Day / Month / Year)	Contact Name and Number

***IMPORTANT: To ensure timely processing of this referral, please attach neuro imaging reports as well as neurology, psychology, psychiatry, and specialist consultation reports that are relevant to the client's condition, symptoms, or diagnosis.**