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Barrie, Ontario L4N 3K4
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Phone 705-734-2178 ext. 228

REQUEST FOR SERVICE

Welcome!

- The NSM ABI Collaborative is a partnership between Ontario Health atHome, York Simcoe Brain Injury Services (YSBIS) a partnership of Mackenzie Health and March of Dimes Canada, Brain Injury Services Muskoka Simcoe (BIS) and March of Dimes Canada (MODC).
- The purpose of the NSM ABI Collaborative is to work as a single system, allowing coordination of the services that may benefit you.
- Referrals can be initiated by the applicant, health care providers, community members and family members/ caregivers with the applicant's consent.
- If you would like Ontario Health atHome (OT, PT, NSG, DT, PSW) services please contact 1-888-721-2222
- Eligibility for service:
  - Between 16 and 65 years of age (persons 65 years and older are evaluated for services on an individual basis)
  - Valid Ontario Health Card
  - Have a diagnosed acquired brain injury
- Please note section 7 – CONSENT FOR SERVICES. Understand that personal health information within this form will be shared and used by the partners of the NSM ABI Collaborative for the purpose of planning and providing coordinated services. If you do not wish your information to be shared among partner agencies, indicate your restrictions under Section 7.

Send form to ONE Agency to ensure coordinated access to NSM ABI Collaborative services.

☐ York Simcoe Brain Injury Services	Fax: 905-773-5176
☐ Brain Injury Services Muskoka Simcoe	Fax: 705-734-1598
☐ March of Dimes Canada	Fax: 905-773-5176

If you require assistance with choosing an agency or feel more than one agency is required, fax ABI System Navigator at 705-734-1598 or call 705-734-2178 ext 228

Section 1– DEMOGRAPHIC INFORMATION

Please complete what you can. All information will be reviewed at your intake meeting.

Legal Name:(last name, first name)		**Date of Birth**: dd/mm/yyyy
Preferred Name:		**Email:**
Street Address: (include apt. #)		**Home Phone:**
City, Province:	**Postal Code:**	**Cell Phone:**
Health Card Number:	**Version Code:**	**Expiry Date:** dd/mm/yyyy
Sex at Birth: ☐ M ☐ F ☐ X	**Gender:**	**Pronouns:**
Relationship status:	**Living situation:** i.e. alone, with spouse, with family	
Ethnicity:	**Primary Language:** **Preferred language:** ☐French ☐English	

Brain Injury Information: **Date of Injury:**_____dd/mm/yyyy

Type of Injury:☐Motor vehicle accident ☐Aneurysm ☐Stroke ☐Fall ☐Meningitis/Encephalitis

☐ Other _____ Was this a work related injury? ☐ Yes ☐ No

Personal Support Network/Emergency contacts. Please list

Name: (last, first)	**Relationship to applicant:**	**Contact Person:** ☐ Yes ☐ No
Address:		
Home Phone Number:	**Alternate Number:** ☐ Cell ☐ Work	**Email:**
Name: (last, first)	**Relationship to applicant:**	**Contact Person:** ☐ Yes ☐ No
Address:		
Home phone number:	**Alternate Number:** ☐ Cell ☐ Work	**Email:**

Primary Care Provider:	**Phone number:**	**Fax number:**
Address:		

Section 2 – REFERRAL SOURCE

Name:	Agency/Title:	Phone:
Street Address:	**City, Province**	**Postal Code:**

Who is completing this application?

☐ Applicant ☐ Referral source as above ☐ Family ☐ Other: other things go her

Name:	Phone:

Section 3. REASON FOR REQUEST FOR SERVICES

Is there a specific service or agency you are looking for?

☐ York Simcoe Brain Injury Services:

- In-home clinical services to support coping and adjusting to emotional and behavioral changes
- Case management
- Home and Community Rehabilitation supports

☐ Brain Injury Services Muskoka Simcoe:

- Adult Day Services
- Individual Rehabilitation Supports
- Educational Groups to develop skills and support independence

☐ March of Dimes Canada

- Weekly adult group activities to promote peer support
- Opportunities to learn beneficial coping strategies
- Supported Life Skill Retreats, Day Trips and Social Opportunities
- Youth Groups and Programs

Reasons for Request for Service (please describe what you would like help with):

In addition to the above, check what you feel you need help with.

☐ Learning to cope after brain injury
☐ Depression
☐ Anxiety
☐ Anger
☐ Impulse control
☐ Initiation / Motivation
☐ Connecting with others (i.e. peer support groups, day programs)
☐ Strategies for planning and organizing daily activities (i.e. meal planning)

Section 4 - PAST AND CURRENT SERVICE INFORMATION

PAST Treatment History

Have you had any treatment for your brain injury either at a facility or from a professional i.e. admission to hospital, rehab facility, neuropsychologist, physiatrist, psychiatrist? If yes list.

Name of Facility/Professional	Address

CURRENT Professional or Legal Services

Are you currently receiving services from any of the following; Psychologist, Psychiatrist, Community Agency i.e. Addictions and Mental Health, Case Manager, Lawyer, Adjuster or other services? If so list:

Name of Professional or Agency	Contact Person	Phone /email

Previous or current involvement with Justice System ☐ Yes ☐ No

Details:

Section 5-MEDICAL INFORMATION

Other Medical Conditions. Please list. (E.g. diabetes, difficulty swallowing, infectious disease, heart, mental health diagnosis)

Current/past psychiatric status. Please describe:

Seizure info Do you have seizures? ☐ Yes ☐ No	Type of seizure: Frequency of seizures:

Do you have allergies? ☐ Yes ☐No
Please list:

Are you on any Medications? ☐ Yes ☐ No

Name of Medication	Dosage	Reason

Do you utilize any assistive devices or mobility aids? (E.g. hearing aid, walker, wheelchair)

Do you receive attendant care? ☐ Yes ☐ No

Can you transfer independently? ☐ Yes ☐ No

History of substance use

Pre-injury history of substance use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Current substance use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Comments: (Type of substance, time of use, purpose of use)

Section 6 - ADDITIONAL INFORMATION

Financial Information

Are you receiving benefits through: ☐ Employment ☐ WSIB

Income source – Optional

☐ ODSP ☐ CPP ☐ Ontario Works ☐ Structured Settlement

☐ Other:_____

Section 7 - CONSENT FOR SERVICES

Consent Statement:

I understand that personal health information within this form will be collected, stored and shared by the agencies of the NSM ABI Collaborative, for the purpose of planning and providing coordinated services.

These agencies do include: Ontario Health atHome, York Simcoe Brain Injury Services, Brain Injury Services Muskoka Simcoe, and March of Dimes Canada.

I understand the agencies listed above will collect and use the following types of information; referral forms, demographics and file updates through written and verbal communication.

I understand that I can withhold or place conditions upon my consent. I understand that I may withdraw my consent at any time by providing notice to any member agency of the NSM ABI Collaborative.

Insert Consent Restrictions:

Consent Type: ☐ Verbal ☐ Written

Name of Person Providing Consent:	**Relationship to applicant:** ☐ Self ☐ SDM ☐ SDM personal care ☐ SDM property *Documentation supporting **active** SDM or POA required

_____ _____

Signature: **Date:**