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REQUEST FOR SERVICE

Welcome!

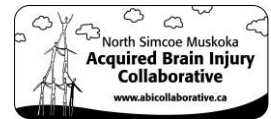
- The NSM ABI Collaborative is a partnership between Ontario Health atHome, York Simcoe Brain Injury Services (YSBIS) a partnership of Mackenzie Health and March of Dimes Canada, Brain Injury Services Muskoka Simcoe (BIS) and March of Dimes Canada (MODC).
- The purpose of the NSM ABI Collaborative is 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.

- | | |
|---|-------------------|
| <input type="checkbox"/> York Simcoe Brain Injury Services | Fax: 905-773-5176 |
| <input type="checkbox"/> Brain Injury Services Muskoka Simcoe | Fax: 705-734-1598 |
| <input type="checkbox"/> 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

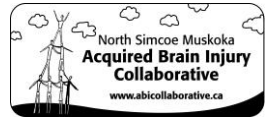




Section 1– DEMOGRAPHIC INFORMATION

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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	Gender:	Pronouns:	
Relationship status:	Living situation: i.e. alone, with spouse, with family		
Ethnicity:	Primary Language: Preferred language: <input type="checkbox"/> French <input type="checkbox"/> English		
Brain Injury Information:		Date of Injury: _____ dd/mm/yyyy	
Type of Injury: <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Aneurysm <input type="checkbox"/> Stroke <input type="checkbox"/> Fall <input type="checkbox"/> Meningitis/Encephalitis <input type="checkbox"/> Other _____ Was this a work related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Personal Support Network/Emergency contacts. Please list			
Name: (last, first)		Relationship to applicant:	Contact Person: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			
Home Phone Number:	Alternate Number: <input type="checkbox"/> Cell <input type="checkbox"/> Work	Email:	
Name: (last, first)		Relationship to applicant:	Contact Person: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			
Home phone number:	Alternate Number: <input type="checkbox"/> Cell <input type="checkbox"/> 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:

Name:	Phone:
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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	Type of seizure:
Do you have seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	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: _____