



North Simcoe Muskoka (NSM) Acquired
Brain Injury (ABI) Collaborative

REQUEST FOR SERVICE

Welcome!

- The NSM ABI Collaborative is a partnership between the North Simcoe Muskoka Community Care Access Centre (NSM CCAC), York-Simcoe Brain Injury Services (YSBIS) a partnership of York Central Hospital 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 which allows us to coordinate the services that may benefit you.
- Please indicate which agency you are referring to under Section 1 -REFERRAL DESTINATION . If you are not sure, please indicate what you are looking for under Section 4- REASON FOR REQUEST FOR SERVICES .
- If you would like NSM CCAC services, please follow NSM CCAC referral process by contacting 1-888-721-2222.
- Referrals can be initiated by the applicant, health care providers, community members and family members/ caregivers with the applicants consent.
- Eligibility for services is: 16 years of age or older (except for NSM CCAC which serves all ages)
Valid Ontario Health Card
Have an acquired brain injury
- Take note of Section 8 - CONSENT FOR SERVICES. Personal health information within this form will be collected, used and disclosed by the partner agencies of the NSM ABI Collaborative for the purpose of planning and providing coordinated services to you. If you do not wish your information to be shared among partner agencies, or any contacts listed on this form, indicate your limitations under Section 8.
- If you have any questions regarding this application please contact our ABI System Navigator at 705-734-2178 ext.228

Supported by / Avec le soutien de



Personal Support Network/Emergency contacts. Please list		
Name: (last, first)	Relationship:	Contact Person: <input type="checkbox"/> yes <input type="checkbox"/> no
Address:		
Home Phone Number:	Alternate number i.e. cell/work:	Email:
Name: (last, first)	Relationship:	Contact Person: Yes No
Address:		
Home phone number:	Alternate number i.e. cell/work:	Email:
Physician:	Phone number:	Fax number:
Physician Address:		
Section 4. REASON FOR REQUEST FOR SERVICES		
Is there a specific service or agency you are looking for? Check all that apply.		
<u>York Simcoe Brain Injury Services</u> Behaviour Consultant Case Manager In Home Rehabilitation Worker <u>Brain Injury Services Muskoka Simcoe</u> Day Program Community Integration Clinic Outreach Worker Individual Rehabilitation Supports <u>March of Dimes Canada</u> Peer Support/Recreation Group		
Reasons for Request for Service (please describe):		
In addition to above, check what you feel you need help with.		
learning to cope with your brain injury depression anxiety anger impulse control connecting with others (i.e. peer support group, day programs, community) strategies for planning and organizing daily activities i.e. meal planning		

Section 5- PAST AND CURRENT SERVICE INFORMATION

Are you receiving any services from any of the following? (check all that apply)

- NSM Community Care Access Centre
- York Simcoe Brain Injury Services
- Brain Injury Services Muskoka Simcoe
- March of Dimes Canada

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 Professionals or 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

Section 6-MEDICAL INFORMATION

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

Seizure info

Do you have seizures?
Yes No

Type of seizure:

Frequency of seizures:

Do you have allergies? no yes Please list:

Are you on any Medications? no yes If yes list.

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? no yes

Can you transfer independently? no yes

History of substance use

Before you injury how much did you drink? daily weekly monthly never

Since your injury how often do you drink? daily weekly monthly never

Since your injury how often do you take non prescription drugs? daily weekly monthly never

Section 7 - ADDITIONAL INFORMATION

Financial Information

Are you receiving benefits through Motor Vehicle Insurance WSIB

Income source – Optional

ODSP CPP Ontario works Structured Settlement other _____

Education/Employment

Are you currently employed? Yes No Employer Name:

Please list your highest level of education attained:

High school Post Secondary Education other_____

Section 8 - CONSENT FOR SERVICES

Consent Statement:

I understand that personal health information within this form will be collected, used and disclosed by the agencies of the NSM ABI Collaborative in accordance with the Personal Health Information Protection Act (PHIPA), for the purpose of planning and providing coordinated services.

These agencies include: North Simcoe Muskoka Community Care Access Centre, York Simcoe Brain Injury Services (a partnership of York Central Hospital and March of Dimes Canada), Brain Injury Services Muskoka Simcoe, and March of Dimes Canada.

I understand that I can withhold or place conditions upon my consent as described on page one under section 8 - CONSENT FOR SERVICES. I understand that I may withdraw my consent at any time, by providing notice to any member agency of the NSM ABI Collaborative

Insert Limitations here:

Consent Source:

Name of Person Providing Consent :

Relationship to applicant:

self

Authorized Substitute Decision Maker

Signature:

Date: