Dale Brain Injury Services Inc.
345 Saskatoon Street, London, ON N5W 4R4
Tel: (519) 668-0023 Toll Free: 1-888-491-3247
Fax: (519)668-6783
Email: admissions@daleservices.on.ca
Website: www.daleservices.on.ca

APPLICATION FOR SERVICE

Client Information		
Name:		Health Card Number and Version Code:
Address:		Postal Code:
Home Phone:	Cell Phone:	Email:
Date of Birth: (dd/mm/yy):		Gender:

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Common-law ☐ Widow(er)

Living Arrangements: ☐ Alone ☐ With Others (specify):

Type of Accommodation: ☐House ☐ Group Home ☐ Apartment Building ☐ Supportive Housing ☐ Long Term Care ☐ Hospital ☐ Shelter ☐ Rooming House ☐Other:

(Optional) Self-described Ethnic Identity-Origin: ☐ North American Indigenous ☐ Asian ☐ Black/of African Descent ☐ White / Caucasian / of European Descent ☐ South Asian ☐ Latin American / Hispanic ☐ Middle Eastern ☐ Other

Preferred Language: ☐English ☐ French ☐ Other:

Contact Person:	Relationship to Client:	Telephone:
Preferred Language: ☐English ☐ French ☐ Other:		Email:

Family Physician / Primary Walk-in Clinic		
Name:	Phone:	Fax:

History:

Date of Acquired Brain Injury (ABI) (dd/mm/yy):

Cause of Injury: ☐Fall ☐Anoxia ☐ Workplace Injury ☐ Assault ☐ Car Collision ☐Tumour ☐Aneurysm ☐ Encephalitis ☐ Sports Injury ☐ Stroke ☐Other:

Treatment History Including Current Services

Have referrals been made to other service providers? ☐ Yes ☐ No

If yes, please check all that apply:

☐ Parkwood Hospital ABI Programs ☐ Outpatient Hospital Services ☐ LHIN
☐ Neurobehavioural Rehabilitation Centre ☐ Addiction Treatment/Services ☐ CMHA
☐ Hamilton Health Sciences ☐ Other Community Based ABI Programs
☐ **Other (please list):**

If referrals to other agencies have been made, can we contact the identified agencies in order to facilitate appropriate and timely service provision? ☐ Yes ☐ No

Additional Information

Wheelchair: ☐ Yes ☐ No **If yes**, is it: ☐ Manual ☐ Motorized
Transfer Assistance: ☐ Yes ☐ No
Assistive Devices: ☐ Yes ☐ No **If yes**, please describe:
Attendant Care: ☐ Yes ☐ No **If yes**, please describe:
Supervision or Assistance with Walking: ☐ Yes ☐ No **If yes**, does it apply to: ☐ Level Surfaces ☐ Stairs ☐ Both
Communication Issues: ☐ Yes ☐ No **If yes,** please describe:
Is there a history of: ☐ Substance Use ☐ Mental Illness ☐ Criminal Offences or Charges ☐ Violent Behaviour
Is your personal safety at risk? ☐ Yes ☐ No
If yes, please describe:
Is there anything further you feel we should be aware of?

Financial Information		
Source of Income:	**Amount of Income per Month: $**	
☐ Ontario Disability Support Program (ODSP)	☐ Insurance Settlement	☐ Ontario Works (OW)
☐ Workplace Safety Insurance Board (WSIB)	☐ Structured Settlement	☐ Old Age Security (OAS)
☐ Long Term Disability (Private)	☐ Full Time Employment	☐ Canadian Pension Plan (CPP)
☐ Inheritance	☐ Part Time Employment	
☐ Income Generating Assets – Please Describe:		

Do you have a Power of Attorney (POA)/Substitute Decision Maker (SDM) for Personal Care?	☐ Yes	☐ No
If yes, do you give consent to obtain or release information to the POA and/or SDM for Personal Care?	☐ Yes	☐ No

Name of POA/SDM for Personal Care:	**Telephone:**

Do you have a Power of Attorney (POA)/Substitute Decision Maker (SDM) for Finances?	☐ Yes	☐ No
If yes, do you give consent to obtain or release information to the POA and/or SDM for Finances?	☐ Yes	☐ No

Name of POA/SDM for Finances:	**Telephone:**

Services offered by Dale Brain Injury Services

☐ **Assisted Living Program:**
24/7 services in a structured, safe environment within the London community to adults living with ABI.

☐ **Supported Independent Living Program:**
Services are available to individuals who require affordable housing and periodic daily access to staff support seven days a week.

☐ **Residential Transitional Services Program:**
Short-term community-based assessment and transitional rehabilitation in a structured 24/7 residential environment that includes assessment, skills training, capacity building with the client, family and their support system, and a seamless transition from hospital to home or long-term care. Available in London only.

☐ **Community Transitional Services Program:**
Short-term community-based assessment, rehabilitation, transitional support and service coordination in the client home and/or their community. Occurs in Elgin, Oxford, London, Middlesex, Grey, Bruce, Huron and Perth counties.

☐ **Intensive Community Transitional Services:**
Shorter term, more intensive services delivered to individuals who are transitioning from hospital to home or long-term care, and/or who require intensive services in order to increase their ability to live as independently as possible in their home environment.

☐ **Group Services:**
Available in Elgin, Oxford, London/Middlesex, Huron, Perth, Grey and Bruce Counties. Services are provided in a group setting focusing on individual and group goal achievement, increased independence and quality of life. Groups provided offer social, recreational, wellness, skill building, exercise and therapeutic activities.

☐ **Emotional Supports:**
Supports are provided to individuals and/or their caregivers with a focus on understanding acquired brain injury and development of coping strategies. Services are provided via face to face sessions, video conference, or teleconference.

☐ **Respite Services:**
Services are provided either in the home or in DBIS' residential setting in the London area for individuals who require short-term respite to provide their care partner some time away from their caregiving duties; for clients who are in crisis or for those who live alone and require support while recovering from an illness or medical procedure and whose needs can be met in the program.

☐ **Short Term Case Management:**
Services are designed to quickly respond to individuals requiring immediate supports to prevent or resolve a crisis situation.

☐ **Consultation & Training:**
Services are available to service providers and include assessment of the needs of the service provider followed by education, direct coaching, mentoring and training on effective interactions with individuals with acquired brain injury.

Required: Diagnosis of ABI (including stroke) is required through verification of medical records
Please attach available reports or complete the provided Consent for Release of Medical Records

☐RAI HC	☐Psychiatry	☐Physiotherapy	☐DSO Support Intensity Scale	☐Neurosurgery
☐Inter RAI-CHA	☐Psychology	☐Speech Therapy	☐Assessment & Discharge Summaries	☐Neuropsychology
☐RAI MDS 2.0	☐OCAN	☐Occupational Therapy	☐DSO Support Intensity Scale	

Referral Information	
Referred By:	Date of Referral:
Position/Agency:	Phone:

Applicant Signature	Legal Guardian/ POA/SDM (if applicable)
Please Print Applicant Name	Please Print Guardian/POA/SDM Name (if applicable)
Date	

Please submit your completed form either by fax to: 519-434-6532 or 519-668-6783 or via email to: admissions@daleservices.on.ca

CONSENT FOR ACCESS OR DISCLOSURE OF PERSONAL INFORMATION and/or PERSONAL HEALTH INFORMATION

DATE (YYYY/MM/DD): _____

PIN#: _____ (for LHSC/SJHC office use)

I CONSENT TO ALLOW: (check ✓ one only)

☐ London Health Sciences Centre ☐ St. Joseph's Health Care, London

☐ Other health facility, practitioner or agency (specify): _____

TO ACCESS/DISCLOSE THE FOLLOWING INFORMATION: (If applicable, specify dates of visits, contacts, hospitalization, treatment, or other information required)

_____

_____

CONCERNING:

Patient / Client Name: _____ Date of Birth: _____

Last Name Given Name Middle Name (YYYY/MM/DD)

Address: _____ HC #: _____

_____ Telephone #: _____

Person / Agency to receive information: Dale Brain Injury Services

Address: 345 Saskatoon Street, London, ON N5W 4R4 Telephone #: 519-668-0023

I understand that this information is to be used by the Recipient for the purpose of:

_____

Patient/client/resident or person (with legal signing authority) consenting to access/disclosure:

Printed Name: _____ Signature: _____

Relationship if other than patient/client/resident: (if patient/client/resident is incapable or deceased)

Address & Telephone # if different than patient/client:

_____ _____

Office Use only - Verification of identity of individual consenting to the access/disclosure:

Form of ID: ❑ Drivers License ❑ Passport ❑ Notarized letter/Lawyer's letter

❑ Other (specify): _____

ID Checked by: _____ _____

Printed Name Signature

PLEASE NOTE: This Consent For Access or Disclosure pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already released.