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| **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  Long Term Care  Other: | | | Group Home  Hospital | | Apartment Building  Shelter | | | | Supportive Housing  Rooming House |
| (Optional) Self-described Ethnic Identity-Origin: | North American Indigenous  White / Caucasian / of European Descent | | | | Asian  South Asian | | | | Black/of African Descent  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: | | |

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| **History:** | | | | | | | |
| **Date of Acquired Brain Injury (ABI) (dd/mm/yy):** | | | | | | | |
| Cause of Injury: | Fall  Tumour | Anoxia  Aneurysm | | Workplace Injury  Encephalitis | Assault  Sports Injury | | Car Collision  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  Neurobehavioural Rehabilitation Centre  Hamilton Health Sciences | | | Outpatient Hospital Services  Addiction Treatment/Services  Other Community Based ABI Programs | | | LHIN  CMHA | |
| **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? | | | | | | | |

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

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| **Referral To** | | | | | |
| **Assisted Living Program:**  Offering 24/7 services in a structured, safe environment within the London community to adults living with ABI. | | | | | |
| **Transitional Services Program:**  Offering short-term community-based assessment and transitional rehabilitation as well as respite supports in the client home and/or in a structured 24/7 residential environment (Residential option available in London only). | | | | | |
| **Outreach Program:**  Individual support sessions are designed to support Clients based on their individual needs. Groups are also available in most counties. Our service area includes Elgin, Oxford, London/Middlesex, Grey, Bruce, Huron and Perth. | | | | | |
| **Outreach Program:**  One-to-one support sessions are designed to support adults living with ABI based on their individual needs. Service area includes Elgin, Oxford, London/Middlesex, Grey, Bruce, Huron and Perth counties. Outreach groups are also available in most counties. | | | | | |
| **Day Services:**  Includes a variety of group services related to community integration, leisure, wellness, vocational/avocational skills, psychosocial skills, and skills building. These services are provided in London at Cornerstone Clubhouse and Gateway to Connections. | | | | | |
| **Consultation & Training:**  Services are available to caregivers, families, service providers and clients to address behavioural, social and cognitive challenges. This includes assessment, development of individualized strategies and support plans, education, and training on program implementation. Our BEST (Behaviour, Education, Support & Training) Team provides an intensive form of consultation and intervention as well as transitional services from Hospital to Long Term Care (LTC). | | | | | |
| **Required: Diagnosis of ABI 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: | |

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| **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: 519-668-6783**

**or via email to: admissions@daleservices.on.ca**