Office Use Only
Date Referral Received:_____
SJHC PKWD MR#: _____

Parkwood Hospital Acquired Brain Injury Program
801 Commissioners Road East, London, Ontario N6C 5J1
Telephone: (519) 685-4000 ext. 42669 **Fax:** (519) 685-4022

Client Information		
Name:	Health Card #:	
Address:	Town:	Postal Code
Phone:	Date of Birth (dd/mm/yy)	Sex: ☐ male ☐ female ☐ other
Marital status: ☐ single, ☐ married, ☐ divorced, ☐ separated, ☐ common-law, ☐ widow(er)		
Preferred language: ☐ English, ☐ French, ☐ other:		

Contact person (if client not person of first contact)		
Name:	Relationship to client:	Telephone:

Reason for Referral

☐ **Seeking confirmation of ABI diagnosis from Physiatry or Neuropsychology** Please forward referral to appropriate fax number:
Neuropsychology, attention Margaret Weiser (519) 685-4022 **Physiatry**, attention Teresa Hawley, (519) 685-4075

☐ **Request referral to multi-disciplinary outpatient rehabilitation program** Referrals to programs described below are not triaged by physiatry, but will be referred on if team deems referral necessitates involvement of physiatry

Multi-disciplinary ABI Outpatient Programs

ABI Outpatient program: Funded through Ministry of Health and **requires physician referral**. Goal-driven, one-on-one and group treatment for individuals with confirmed ABI diagnosis. Services include Occupational Therapy, Physiotherapy, Psychology/Neuropsychology testing, Speech Language Pathology, and Social Work. Audiology is also available at a cost to the client (i.e., fee for service)

ABI Outreach Program: Funded through Ministry of Health and **does not require physician referral.** Consultation, support, training, and case coordination for people with an ABI, their families, caregivers, and other service providers. Focused on enabling persons with ABI to reintegrate and maintain in their own community.

NeuroTrauma Rehab Program: Not funded through Ministry of Health. Appropriate for individuals who are willing to self-pay or qualify to access funding through workplace insurance (i.e., WSIB), motor vehicle insurance, or extended health benefits. Individuals must be over 16 years of age, live within one of 10 Southwestern Ontario counties, and have sustained neurological trauma from accidents of disease (i.e., not solely ABI diagnoses). Services include Audiology, Occupational Therapy, Physiotherapy, Psychology/Neuropsychology, Rehabilitation Therapy, Speech Language Pathology, and Social Work.

Regional Coordinator of ABI Services: Appropriate for individuals with a confirmed ABI diagnosis. Case management for those with multiple/complex care needs, difficulties coping with a mental health diagnosis, and/or substance use issues. The goal is to facilitate meaningful community integration for these clients.

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

Cause (select appropriate below):

☐ Fall	☐ Assault	☐ Aneurysm	☐ Car Collision	☐ Sports Injury
☐ Anoxia	☐ Tumour	☐ Encephalitis	☐ Workplace injury	☐ Other:_____

If Workplace injury or Car collision, include the following contact information (name and telephone/fax):
Claim number:_____ Case Manager/Adjustor:_____ Telephone: _____Fax:_____
Lawyer:_____ Telephone: _____Fax:_____

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Presenting Difficulties

- ☐ Difficulty with memory
- ☐ Difficulty paying attention
- ☐ Difficulty following or participating in conversations
- ☐ Confusion
- ☐ Poor judgment
- ☐ Lack of initiation
- ☐ Difficulty controlling emotions
- ☐ Perceptual difficulties
- ☐ Swallowing Issues
- ☐ Fatigue
- ☐ Sleep issues
- ☐ Depression
- ☐ Vision changes (not associated with acuity or age)
- ☐ Tinnitus
- ☐ Noise sensitivity
- ☐ Difficulty hearing in background noise
- ☐ Physical problems
- ☐ Pain and/or headaches
- ☐ Problems with balance
- ☐ Dizziness/faintness
- ☐ Vertigo

Relevant History

- ☐ Previous brain injury
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Disease
- ☐ Cancer
- ☐ Dementia
- ☐ Substance use
- ☐ Mental Illness
- ☐ Criminal offences or charges
- ☐ Violent behaviour
- ☐ Other (please list):

Present Issues with ☐ Criminal offences or charges, ☐ Violent behavior, ☐ Substance use, ☐ Mental Illness

Is there anything further you feel we should be aware of?

_____

Additional Services Received: If aware of involvement of additional services, please indicate below

- ☐ Dale Brain Injury Services
- ☐ CCAC
- ☐ CMHA
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Speech Language Pathology
- ☐ Massage
- ☐ Chiropractic
- ☐ Social Work
- ☐ Other (please describe):

Family Physician

Name:	Phone:	Fax:
Physician Signature (required for ABI Outpatient Program)		

Referral Information

Name:	Phone:	Fax:
Position/Agency:	Date of Referral:	

Thank you. Please Fax completed form to 519-685-4551