Providence Care

PERSONAL HEALTH INFORMATION

COMMUNITY BRAIN INJURY SERVICES (CBIS)

REFERRAL

Note: Prior to completing referral, please refer to attached eligibility criteria.
For further information or help to complete this form contact:

Kingston	**Brockville**	**Belleville**
Community Brain Injury Services LaSalle Mews 303 Bagot Street, Suite 401 Kingston, ON K7K 5W7 Phone: (613) 547-6969 Fax: (613) 547-6472	Community Brain Injury Services 23 Abbott St. Brockville, Ontario K6V 4A5 Phone: (613) 342-1613 Fax: (613) 342-1055	Community Brain Injury Services Quinte Mall Office Tower 100 Bell Blvd., Suite 335 Belleville, Ontario K8P 4Y7 Phone (613) 968-8888 Fax : (613) 968-9220

Client or Substitute Decision Maker has provided informed consent to make referral: ☐ **Yes** ☐ **No**

Client/Substitute Decision Maker Name (please print)**:** _____ **Signature:** _____

Client Name: _____

☐ **Male** ☐ **Female**

Status: ☐ **Divorced** ☐ **Married** ☐ **Partner** ☐ **Single** ☐ **Widowed** ☐ **Separated**

Address: _____

_____

Postal Code: _____ **County:** ☐ **KFLA** ☐ **LLG** ☐ **HPE** ☐ **OTHER** _____

Telephone: _____

Permission to leave voicemail ☐ **Yes** ☐ **No**

Date of Birth: (YYYY/MM/DD) _____ **Health Card Number:** _____

Version Code & Expiry Date: _____

Reason for Referral: How can we help? _____

_____

_____

Is client legally capable with respect to personal care? ☐ **Yes** ☐ **No**

Is client legally capable with respect to finances? ☐ **Yes** ☐ **No**

Contact information for substitute decision maker (if applicable) **Name:** _____

Address: _____ **Telephone Number:** _____

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REFERRAL

CBIS provides services to adults who have sustained a moderate to severe brain injury. In order to determine if a person meets our criteria for service, we review information regarding GCS, loss of consciousness, and CT/MRI/other imaging results. Forwarding records that report on one or more of these areas, with the referral, will allow us to process your request for service more efficiently.

Brain Injury: **Date:** (YYYY/MM/DD)_____ **Cause:** _____

Above Medical Reports Attached? ☐ **Yes** ☐ **No** **Reports will be forwarded by:** _____

Living Situation: ☐ **Alone** ☐ **With Family** ☐ **With Spouse** ☐ **Other** ☐ **Specify:** _____

Name: _____

Emergency Contact: **Name:** _____ **Relationship:** _____

Address: _____

Telephone: _____

Other service providers at this time:

_____

_____

Funding: ☐ **No** ☐ **Yes** ☐ **WSIB** ☐ **Motor Vehicle Insurance**

If yes, specify: **Name of Company:** _____

Name/Contact Person: _____

Address:_____

Telephone: _____ **Identification/Claim No.:** _____

Family Doctor: _____ **Telephone:** _____

Address:_____

Referred By: _____

Name: _____

Address: _____

Telephone: _____ **Agency/Relationship:** _____

Signature: _____ **Date** (YYYY/MM/DD)**:** _____

303 BAGOT ST, LaSALLE MEWS, STE 401, KINGSTON, ONTARIO K7K 5W7 (613) 547-6969 FAX 547-6472