

KFLA ABI AND ADDICTION/MENTAL HEALTH COLLABORATIVE REFERRAL

Note: Prior to completing referral, please refer to service information sheet, For further information or help to complete this form contact:

SEO ABI System Navigator
303 Bagot Street, LaSalle Mews, Suite 401
Kingston, Ontario K7K 5W7
Phone: (613) 547-6969 Fax: (613) 547-6472

Client or Substitute Decision Maker has provided informed consent to make referral: Yes No
(if ABI and Addiction/Mental Health Collaborative consent form has been signed, please attach)

Client Name: _____ Male Female Other (please specify) _____

Address: _____

Status: Divorced Married Partner Single Widowed Separated

Postal Code: _____ **County:** KFLA

Telephone: _____ HPE

Date of Birth: _____ LLG

Health Card Number and Version Code: _____

Living Situation: Alone With family **Name:** _____

With Spouse **Name:** _____ Other **Specify:** _____

Reason for Referral: What are the unmet needs and risks? (refer to the definition of high risk)

Risk factors to consider (please provide specifics)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Suicide | <input type="checkbox"/> Crime Victimization |
| <input type="checkbox"/> Sexual Violence | <input type="checkbox"/> Basic Needs | <input type="checkbox"/> Drugs | <input type="checkbox"/> Cognitive Impairment |
| <input type="checkbox"/> Self Harm | <input type="checkbox"/> Physical Violence | <input type="checkbox"/> Elder Abuse | <input type="checkbox"/> Missing School |
| <input type="checkbox"/> Poverty | <input type="checkbox"/> Gangs | <input type="checkbox"/> Gambling | <input type="checkbox"/> Physical Health |
| <input type="checkbox"/> Criminal Involvement | <input type="checkbox"/> Emotional Violence | <input type="checkbox"/> Supervision | <input type="checkbox"/> Negative Peers |
| <input type="checkbox"/> Missing/Runaway | <input type="checkbox"/> Social Environment | <input type="checkbox"/> History of Trauma | <input type="checkbox"/> Financial Vulnerability |
| <input type="checkbox"/> Marginalized Population | <input type="checkbox"/> Housing/Risk of LTC Admission | | |
| <input type="checkbox"/> Antisocial/Negative Behaviour | | <input type="checkbox"/> Threat to Public Health and Safety | |
| <input type="checkbox"/> Unemployment/Risk of losing employment | | <input type="checkbox"/> Lack of History of Formal/Informal Supports | |

High Risk definition: "individuals or families facing a number of risk factors that affect multiple areas of the individual's life and in all likelihood will lead to something bad happening and happening soon. These could include individuals that may be at risk of doing harm to others, becoming a victim, relapsing on a treatment plan, and/or ending up on the street."

Client Surname: _____ First Name: _____ DOB (YYYY/MM/DD): _____

We encourage applicants of designated groups to self-identify: _____

Primary Language: English French Other _____

Interpreter Required Yes No

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:** _____

The ABI and Addiction/Mental Health Collaborative provides a forum for service providers to meet and discuss how best to meet the needs of the referred individual/family affected by known or suspected moderate to severe ABI complicated by known or suspected mental health issues and/or substance use issues.

What is the evidence of a known or suspected moderate to severe brain injury? E.g. GCS, PTA, Imaging, etc.

What is the evidence of a known or suspected mental health and/or substance use disorder? E.g. psychosis, mood disturbance, anxiety, etc.

Previous and Current providers:

Funding: Yes No WSIB Motor Vehicle Insurance

Primary Care Provider: _____ **Telephone:** _____

Address: _____

Referred by: _____

Name: _____

Address: _____

Telephone: _____ **Agency:** _____

Signature: _____ **Date:** _____