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

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

Contact Information of Substitute Decision-Maker (if applicable) Name: _____

Address: _____ Telephone Number: _____

Client Name: _____ Preferred Name: _____

Gender: ☐ male ☐ female ☐ other: _____

Pronouns: ☐ he/him ☐ she/her ☐ them/they ☐ other: _____

Address: _____

Postal Code: _____ County: ☐ KFLA ☐ LLG ☐ HPE ☐ Other: _____

Telephone: _____ Permission to leave message: ☐ Yes ☐ No

Date of Birth: _____ Health Card Number: _____

Version Code & Expiry: _____

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

Living Situation: ☐ Alone ☐ with family ☐ with spouse ☐ other: _____

Emergency Contact: _____ Telephone Number: _____

Is the client legally capable with respect to:

Personal Care: ☐ Yes ☐ No Finances: ☐ Yes ☐ No

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CBIS provides services to adults who have 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: _____ Cause: _____

Concussion Diagnosis? ☐ Yes ☐ No ☐ Unknown

Medical Reports Attached? ☐ Yes ☐ No – reports to be forwarded by:_____

Reason for Referral:

Risk Assessment: (check all that apply):

☐ History of violence ☐ Verbal/physical aggression ☐ Alcohol/substance misuse ☐ other: _____

Medical Conditions: ☐ Yes (please indicate below) ☐ No ☐ N/A

_____

Psychiatric Diagnoses: ☐ Yes (please indicate below) ☐ No ☐ N/A

_____

Other Current Service Providers:

_____

_____

Family Doctor: _____ Phone: _____ Fax: _____

Address: _____

Third Party Funding (ie. WSIB or Motor Vehicle Insurance): ☐ Yes (please indicate below) ☐ No

Company Name: _____ Contact Name: _____

Address: _____

Phone: _____ Identification / Claim # _____

Referred By – Name: _____ Relationship: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____