Regional Acquired Brain Injury Outpatient Services
Allied Health Referral Form

Parkwood Institute, Main Building
P.O. Box 5777, Station B
London, Ontario, N6A 4V2
Phone 519-685-4064 Toll Free: 1-866-484-0445
Fax: 519-685-4824

Referral Date:	Date Referral Received:	Parkwood Institute MR#:

PATIENT'S PERSONAL INFORMATION: (Place sticker here)

Last Name:	First Name: ☐Male☐Female

Birth Date: (year/month/day)	Age:	☐Single ☐ Married ☐Widowed ☐Separated ☐Divorced

Address- Street:	City:	Province:

Postal Code:	Telephone: (Home)	Telephone: (Other)

E-mail:	Health Card #:

REASON FOR REFERRAL: (Please select one that applies)

☐ **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, Speech Language Pathology, and Social Work.

☐ **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

☐ **Regional ABI Navigator:** 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.

☐ **Neuropsychology:** Funded through Ministry of Health and requires physician referral. Assessment of individuals with confirmed ABI diagnosis to evaluate cognitive function, assist with diagnosis and plan treatment.

MEDICAL INFORMATION:

Date of Injury/onset: (day/month/year)	☐ Traumatic ☐ Non-Traumatic GCS Score: _____ LOC: ☐ Yes ☐ No

Cause of Brain Injury:

☐ Fall ☐ Falling object/From an object ☐ Assault ☐ CVA (Stroke/Aneurysm)
☐ Sports Injury ☐ Motor Vehicle Accident (MVA) ☐ Anoxia ☐ Tumour
☐ Workplace Injury ☐ Other: _____

Has there been 3rd party funding? ☐ Auto Insurance ☐ Private Insurer ☐ WSIB ☐ Other: _____

Please attach relevant medical records of ABI: **Additional Records Faxed with Referral ☐Yes**

☐ CT/MRI of Head ☐ C-Spine Imaging ☐ Emergency/Operative/Consultation Notes ☐ Social Work
☐ Occupational Therapy ☐ Physiotherapy ☐ SLP ☐ Other: _____

☐**Criminal offences or charges** ☐**Violent Behaviour** ☐**Substance Use** ☐**Mental Health Illness**

If yes, please describe: _____

_____

FAX REFERRAL - DATE: (dd/mm/yyyy) _____ (ABI Outpatient Referral)
Last Name: _____ First Name _____
Date of Birth: _____ Age: _____ HIN# _____

Allergies: ☐ No ☐ Yes (list) _____

Current Medications: (Include prescription and non-prescription medications)

Medication	Dose (include units)	Route	Frequency	Prescribed by

Medication List Complete: ☐ **Yes** ☐ **No → Additional List Faxed with Referral?** ☐ **Yes**

Relevant medications previously trialed: _____
_____
_____

ISSUES IDENTIFIED:

PAST MEDICAL HISTORY/ISSUES: ☐ None Identified

_____
_____

Have any therapies or treatments been received since the brain injury? ☐ Yes ☐ No

If yes, what therapies/services have been received? ☐Physiotherapy ☐ Occupational Therapy
☐ Massage ☐ Acupuncture ☐ Social Work ☐ Audiologist ☐ Optometrist
☐ Speech Language Pathology ☐ Other: _____

Presenting Difficulties:

☐ Difficulty with Memory	☐ Perceptual difficulties	☐ Noise sensitivity
☐ Difficulty paying attention	☐ Swallowing Issues	☐ Balance/Falls
☐ Difficulty following or participating in conversations	☐ Fatigue	☐ Lack of initiation
	☐ Sleep Issues	☐ Physical problems
☐ Confusion	☐ Depression and Anxiety	☐ Dizziness/vertigo
☐ Poor Judgment	☐ Vision changes (due to injury)	☐ Headaches
☐ Difficulty controlling emotions	☐ Tinnitus (ringing in ears)	☐ Other: _____

Is there anything else we should be aware of? _____
_____

REFERRING PHYSICIAN: (Place sticker here)

Printed Name:	Signature:
Phone:	Fax:

WHAT HAPPENS NEXT?

We will contact you within 7 business days to confirm receipt of your referral and to request missing information. You will receive a notification of the triage decision. **To expedite this process, please ensure that you have provided all requested clinical information and contact information with this referral.**