Office Use Only
Date Referral Received:_____________
Parkwood Institute MR#:

Parkwood Institute Acquired Brain Injury Program
550 Wellington Rd. London, Ontario N6C 0A7
Telephone: 519 685 4064 **Fax:** 519 685-4551 **Toll Free:** 1-866-484-0445

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

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

Reason for Referral
☐ Request referral to multi-disciplinary outpatient rehabilitation program Please note: **Referrals are not reviewed by physiatry.**
Please note: **If you are seeking confirmation of ABI diagnosis, a separate referral must be made to physiatry .Please complete physiatry referral form and fax to:** Teresa Hawley, (519) 685-4075. Physiatry Referral Form can be found by clicking HERE, or going to this link: https://www.sjhc.london.on.ca/sites/default/files/pdf/referralform_physiatry_outpatient_referral.pdf

ABI 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, 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.
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 or disease. Services include Audiology, Occupational Therapy, Physiotherapy, 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): ____

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

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

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

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

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Family Physician

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

Referral Information

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

Please Fax completed form to 519 685-4551