fraserhealth

ACQUIRED BRAIN INJURY SERVICES
Referral by Healthcare Provider

Acquired Brain Injury Services: 201-9440 202 Street, Langley, BC V1M 4A6 Intake: 604-514-7460 Email: ABI@fraserhealth.ca

Please fax completed referral form to 604-528-5454

A. Your Information		
Last Name:	First Name:	Preferred Name:
Date of Birth (DD/MM/YYYY):	Personal Health Number:	Preferred Language:

Pronouns: ☐ He/His/Him ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other, please specify: _____

Gender: ☐ Male ☐ Female ☐ Identify As: _____

Address (City, Province, Postal Code):

Main Phone Number:	Alternative Phone Number:	Email:
Other Person to Contact:	Relationship:	Phone Number:
Primary Health Care Provider Name:	Professional Title:	Phone Number:

Do you wish to identify as an Aboriginal / Indigenous person? ☐ Yes ☐ No ☐ Prefer not to answer

If yes, select **ALL** that apply:

☐ First Nations ☐ Inuit ☐ Metis ☐ Status Non-Status ☐ Other, please specify: _____

Citizenship Status:

☐ Canadian Citizen ☐ Landed Immigrant ☐ Sponsored Immigrant ☐ Refugee Status ☐ VISA Permit

☐ Other, please specify _____

B. Referral Source		
Referring Person Name:	Relationship:	Phone Number:

C. About your brain injury	
Date of Injury:	Which hospital or clinic did you attend, if any?

Is this injury from:

☐ Motor Vehicle Accident ☐ Work-Related Injury ☐ Victim of Crime ☐ Other, please specify: _____

Type of Brain Injury:

☐ Aneurysm
☐ Anoxia/Hypoxia
☐ Arteriovenous Malformation
☐ Hemorrhage
☐ Hemorrhagic - Stroke
☐ Infection
☐ Ischemic - Stroke
☐ Traumatic Brain Injury
☐ Tumour
☐ Other (please specify) _____

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D. Evidence of Brain Injury

Choose one:

- ☐ CT Scan Date: _____
- ☐ MRI Date: _____
- ☐ Physiatry Report Date: _____
- ☐ Neurology Report Date: _____
- ☐ Other Report Date: _____

E. Programs the client has been involved with (Past and Present)

- ☐ ABI Services
- ☐ First Nation's Health Services
- ☐ CLBC
- ☐ Mental Health Services
- ☐ Home Health Services
- ☐ Substance Use Services
- ☐ Outpatient Rehab Service
- ☐ Familiar Faces Program
- ☐ Inpatient Rehab

F. Client Factors

- ☐ Mental Health Concerns
- ☐ Personal Care Needs
- ☐ Criminal History and/or on Probation
- ☐ History of Unstable Housing
- ☐ Frequent ER Admissions
- ☐ Active or Recent History of Substance Use
- ☐ Currently Requires Supervision At All Times
- ☐ Complex Medical Issues - Ongoing
- ☐ Behavioural Concerns
- ☐ Cognitive Impairment (Moderate-Severe)
- ☐ Concerns of Abuse/Neglect/Self Neglect
- ☐ Other, please specify: _____

Additional Information (i.e. Support Systems, Other Concerns):

G. Reason for referral

What is the client's current living environment?

☐ Alone ☐ With Family ☐ With Friends ☐ Other, please specify: _____

Please tell us what activities the client finds challenging to complete daily.

☐ Getting dressed ☐ Showering ☐ Using the toilet ☐ Completing household duties ☐ Focussing ☐ Sleeping

☐ Managing money ☐ Paying Bills ☐ Shopping ☐ Getting around the community ☐ Watching television

☐ Other, please specify: _____

Please provide more information about the types of support the client requires.

Is there anything else you would like us to know about the client?

Is the client/ family aware of this Referral? ☐ **Yes** ☐ **No**