North Simcoe Muskoka (NSM)
Acquired Brain Injury (ABI)
Collaborative

REQUEST FOR SERVICE

Welcome!

- The NSM ABI Collaborative is a partnership between the North Simcoe Muskoka Local Health Integration Network (NSM LHIN), York-Simcoe Brain Injury Services (YSBIS) a partnership of Mackenzie Health and March of Dimes Canada, Brain Injury Services Muskoka Simcoe (BIS) and March of Dimes Canada (MODC).

- The purpose of the NSM ABI Collaborative is to work as a single system, allowing coordination of the services that may benefit you.

- Referrals can be initiated by the applicant, health care providers, community members and family members/ caregivers with the applicants consent.

- If you would like NSM LHIN (OT, PT, SLP, NSG, DT, PSW) Services please follow the NSM LHIN process by contacting 1-888-721-2222

- Eligibility for services is:
  - Between 16 and 65 years of age (persons 65 years and older are evaluated for services on an individual basis)
  - Valid Ontario Health Card
  - Have a diagnosed acquired brain injury

- Please note Section 8 - CONSENT FOR SERVICES. Understand that personal health information within this form will be shared and used by the partners of the NSM ABI Collaborative for the purpose of planning and providing coordinated services to you. If you do not wish your information to be shared among partner agencies, indicate your restrictions under Section 8.

Send form to ONE Agency to ensure coordinated access to NSM ABI Collaborative services.

□York Simcoe Brain Injury Services	Fax: 905-773-5176
□Brain Injury Services Muskoka Simcoe	Fax: 705-734-1598
□March of Dimes Canada	Fax: 905-773-5176

If you need direction to select one agency, contact the NSM ABI System Navigator at 705-734-2178 ext 228

Supported by / Avec le soutien de
Ontario
North Simcoe Muskoka Local Health Integration Network
Réseau local d'intégration des services de santé de Simcoe Nord Muskoka

Mackenzie Health

BIS BRAIN INJURY SERVICES MUSKOKA • SIMCOE

MARCH OF DIMES CANADA LA MARCHE DES DIX SOUS DU CANADA

Section 1– DEMOGRAPHIC INFORMATION
Please complete what you can. All information will be reviewed at your intake meeting.

Legal Name:(last name, first name)		**Date of Birth**: dd/mm/yyyy
Street Address: (include apt. #)		**City, Province:**
Postal Code:	**Home Phone:**	**Postal Code:**
Email:	**Legal Gender:** ☐M ☐F ☐X	**Health Card Number**: Version code if any:
Marital status:	**Living situation:** i.e. alone, with spouse, with family	
Ethnicity:	**What is your mother tongue:** **Preferred official language:** ☐French ☐English	

Brain Injury Information: **Date of Injury:**_____dd/mm/yyyy

Type of Injury: ☐motor vehicle accident ☐aneurysm ☐stroke ☐fall ☐meningitis/encephalatis ☐other_____ Was this a work related injury? ☐Yes ☐No

Personal Support Network/Emergency contacts. Please list

Name: (last, first)	**Relationship to you:**	**Contact Person:** ☐Yes ☐No
Address:		
Home Phone Number:	**Alternate Number i.e.** ☐cell ☐work	**Email:**
Name: (last, first)	**Relationship:**	**Contact Person:** ☐Yes ☐No
Address:		
Home phone number:	**Alternate Number i.e.** ☐cell ☐work	**Email:**
Physician:	**Phone number:**	**Fax number:**
Physician Address:		

Section 2 – REFERRAL SOURCE

Name:	**Agency/Title:**	**Phone:**
Street Address:	**City, Province**	**Postal Code:**

Who is completing this application?
☐applicant ☐referral source as above ☐family ☐other:

Name:	**Phone:**

Section 3. REASON FOR REQUEST FOR SERVICES

Is there a specific service or agency you are looking for?

☐ York Simcoe Brain Injury Services:

- In-home clinical services to support coping and adjusting to emotional and behavioral changes
- Case management
- Home and Community Rehabilitation supports

☐ Brain Injury Services Muskoka Simcoe:

- Adult Day Services
- Individual Rehabilitation Supports
- Educational Groups to develop skills and support independence

☐ March of Dimes Canada

- Weekly adult group activities promote Peer Support and offer opportunities to learn beneficial coping strategies
- Supported Life Skill Retreats, Day Trips and Social Opportunities
- Youth Groups and Programs

Reasons for Request for Service (please describe what you would like help with):

In addition to the above, check what you feel you need help with.

☐learning to cope after your brain injury ☐depression ☐anxiety ☐anger ☐impulse control ☐connecting with others (i.e. peer support group, day programs, community) ☐strategies for planning and organizing daily activities i.e. meal planning

Section 4 - PAST AND CURRENT SERVICE INFORMATION

PAST Treatment History

Have you had any treatment for your brain injury either at a facility or from a professional i.e. admission to hospital, rehab facility, neuropsychologist, physiatrist, psychiatrist? If yes list.

Name of Facility/Professional	Address

CURRENT Professional or Legal Services

Are you currently receiving services from any of the following; Psychologist, Psychiatrist, Community Agency i.e. Addictions and Mental Health, Case Manager, Lawyer, Adjuster or other services? If so list:

Name of Professional or Agency	Contact Person	Phone /email

Previous or current involvement with Justice System ☐Yes ☐No

Details:

Section 5-MEDICAL INFORMATION

Other Medical Conditions. Please list. (E.g. diabetes, difficulty swallowing, infectious disease, heart, mental health diagnosis)

Current/past psychiatric status. Please describe:

Seizure info Do you have seizures? ☐Yes ☐No	Type of seizure: Frequency of seizures:

Do you have allergies? ☐Yes ☐No

Please list:

Are you on any Medications? ☐Yes ☐No

Name of Medication	Dosage	Reason

Do you utilize any assistive devices or mobility aids? E.g. hearing aid, walker, wheelchair.

Do you receive attendant care? ☐Yes ☐No

Can you transfer independently? ☐Yes ☐No

History of substance use

Pre-injury history of substance use: ☐daily ☐weekly ☐monthly ☐never

Current substance use: ☐daily ☐weekly ☐never

Section 6 - ADDITIONAL INFORMATION

Financial Information

Are you receiving benefits through: ☐ Employment ☐ WSIB

Income source – Optional

☐ ODSP ☐ CPP ☐ Ontario works ☐ Structured Settlement

☐ other _____

Section 7 - CONSENT FOR SERVICES

Consent Statement:

I understand that personal health information within this form will be collected, stored and shared by the agencies of the NSM ABI Collaborative, for the purpose of planning and providing coordinated services.

These agencies do include: North Simcoe Muskoka Local Health Integration Network, York Simcoe Brain Injury Services (a partnership of Mackenzie Health and March of Dimes Canada), Brain Injury Services Muskoka Simcoe, and March of Dimes Canada.

I understand the agencies listed above will collect and use the following types of information; referral forms, demographics and file updates through written and verbal communication.

I understand that I can withhold or place conditions upon my consent. I understand that I may withdraw my consent at any time, by providing notice to any member agency of the NSM ABI Collaborative

Insert Consent Restrictions:

Consent Type: ☐ Verbal ☐ Written

Name of Person Providing Consent :	**Relationship to applicant:** ☐ Self ☐ SDM ☐ SDM personal care ☐ SDM property
Signature:	**Date:**