Mailing Address 21 Essa Road Unit 1
Barrie, Ontario L4N 3K4
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Phone 705-734-2178 ext. 228

# REQUEST FOR SERVICE

## Welcome!

- The NSM ABI Collaborative is a partnership between Ontario Health at Home, 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 be benefit you.
- Referrals can be initialed by the applicant, health care providers, community members and family members/ caregivers with the applicants consent.
- If you would like Ontario Health at Home (OT, PT, NSG, DT, PSW) services please contact 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 7 – CONSENT FOR SERVICES. Understand that persona 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 7.

**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**

**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 |
| **Preferred Name:** | | **Preferred Pronoun:** |
| **Street Address:** (include apt. #) | | **City, Province:** |
| **Postal Code:** | **Home Phone:** | **Cell Phone:** |
| **Email:** | **Legal Gender:** ☐ M ☐ F ☐ X | **Health Card Number** (Version Code) |
| **Relationship 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/Encephalitis ☐ 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:** ☐ Cell ☐ Work | **Email:** |
| **Name: (last, first)** | **Relationship:** | **Contact Person:** ☐ Yes ☐ No |
| **Address:** | | |
| **Home phone number:** | **Alternate Number:** ☐ 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 brain injury
☐ Depression
☐ Anxiety
☐ Anger
☐ Impulse control
☐ Connecting with others (i.e. peer support groups, 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**<br>Do you have seizures? ☐ Yes ☐ No | Type of seizure:<br><br>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 ☐ Monthly ☐ 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: Ontario Health at Home, 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:**<br>☐ Self ☐ SDM<br>☐ SDM personal care ☐ SDM property |
|---|---|

_____ _____

**Signature:** **Date:**