

Date of Application: _____ Name of Client: _____

Date of Birth: _____ Age: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Program Being Applied To: On-Site Outreach

REFERRAL SOURCE

- | | |
|---|--|
| <input type="checkbox"/> Long Term Care Facility | <input type="checkbox"/> Carewest Dr. Vernon Center – 2 East |
| <input type="checkbox"/> Assisted Living/Group Home | <input type="checkbox"/> Halvar Jonson Centre for Brain Injury |
| <input type="checkbox"/> Self | <input type="checkbox"/> Community Accessible Rehabilitation – CAR |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Family |

REFERRING PERSON

Name: _____ Relationship to Client: _____

Phone: _____ Email: _____

CLIENT INFORMATION

Alberta Health Care #: _____

Calgary Transit Access: Yes No If yes, please provide number: _____

If no, what transportation method do you use? Family/Friends Taxi Public Other

Do you have private insurance or other coverage for therapeutic services? Yes No

If Yes: Motor Vehicle Accident Insurance Other Insurance (DVA, Treaty, WCB)

Is the client their own guardian? Yes No

Note: In the event the client is not their own guardian, please provide a copy of the relevant legal document (enacted personal directive or guardianship) indicating who is.

MEDICAL HISTORY

Date of Injury or Onset: _____ Primary Diagnosis: Traumatic Brain Injury Stroke

Admitting Hospital: _____

Other Medical Conditions:

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism/Substance Abuse | <input type="checkbox"/> Glaucoma/Cataracts |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Hypo/Hyper Thyroid |
| <input type="checkbox"/> Auto Immune | <input type="checkbox"/> Mental Illness: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Infectious Disease (HIV, MRSA, Hepatitis) | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Other: _____ | |

Do any of the following apply to the client?

- Requires Supplemental Oxygen Has PEG Tube Has NG Tube Has Tracheotomy

Is the client medically stable? Yes No

Therapies Previously Received (Include Special Visits and Rehabilitation):

Current Therapies:

Goals of Care: R1 R2 R3 M1 M2 C1 C2 Unknown

Tolerance for Active Rehabilitation Per Day: 1 Hr or Less 2 Hrs 3 Hrs Over 3 Hrs

What are the client's goals for therapy?

1. _____
2. _____
3. _____

Has this referral been discussed with Calgary Brain Injury Program? Yes No Unknown

Family Physician: _____ Phone Number: _____

Has the client seen a neurologist or physiatrist? Yes No

If yes, provide name: _____

SOCIAL HISTORY

Highest Level of Education: _____ Marital Status: _____

Most Recent Employment: _____

Supportive Family Members: _____

Other Supports: _____

Is there any other relevant information we should know about?

CURRENT STATUS

Swallowing: Concerns and/or Diet Modifications:

Aphasic: Yes No

Is English the client's first language? Yes No If no, what is? _____

Is an interpreter required? Yes No

Mobility Aids Used (e.g., canes, braces, wheelchairs):

Has client had any falls in the last three months? Yes No If yes, how many? _____

Does the client exhibit any of the following behaviours?

- Physical Aggression Verbal Aggression Social Inappropriateness
 Difficulty Regulating Emotions Other: _____

If yes to any of the above, please provide details:

Does the client have regular access to all equipment required for virtual therapy (computer, iPad, camera, internet connection, etc.)? Yes No

Does the client have experience with virtual therapy? Yes No

Does the client have a support person regularly available to assist with virtual therapy? Yes No

Is the client aware and agreeable to this referral? Yes No

How many times a week does the client participate in the community (e.g., going shopping, visiting friends/family, attending church or community group activity)? _____

Provide examples of clients' community outings: _____

Additional Comments:

Application Completed By: _____

Signature: _____ Date: _____