arbi Association for the Rehabilitation of the Brain Injured

CLIENT APPLICATION

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

- ☐ Long Term Care Facility
- ☐ Assisted Living/Group Home
- ☐ Self
- ☐ Other: _____
- ☐ Carewest Dr. Vernon Center – 2 East
- ☐ Halvar Jonson Centre for Brain Injury
- ☐ Community Accessible Rehabilitation – CAR
- ☐ Family

REFERRING PERSON

Name: _____ Relationship to Client: _____

Phone: _____ Email: _____

Required Documents: ☐ Medical Discharge Report ☐ Recent Therapy Progress Notes

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

Please identify available funding source(s) for physiotherapy, occupational therapy, speech therapy, and/or psychological services/counselling services:

- ☐ Workers' Compensation
- ☐ First Nations Bands
- ☐ Military Service Branches
- ☐ Private/Personal Payment
- ☐ Other: _____
- ☐ Commercial Insurance: Accident Settlement
- ☐ Commercial Insurance: Health/Wellness Programs
- ☐ I do NOT have any funding sources for the services listed

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:

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

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: _____