Capital Health

Acquired Brain Injury

Outreach, Day Program, and Coordinator-ABI Ambulatory Care Teams Referral Form

Fax to: 425-6574

Patient name _____
Contact Person (name)_____
Date of birth: YY____ MM____ DD____
Address:_____
Phone:(H)_____ (W)_____
Family Physician:_____
HCN:_____ Exp.Date:_____
HUN:_____

SECTION A

CLIENT NAME: _____ REFERRAL DATE (YYYY/MM/DD):_____

PRIMARY DIAGNOSIS: _____

DATE & CAUSE OF ABI: _____

RELEVANT PAST MEDICAL HISTORY:_____

Is client aware of this referral? ☐ Yes ☐ No

CURRNT LIVING STATUS

☐ Living in community: ☐ Alone ☐ With supports (specify): _____

☐ In hospital: Hospital name & unit: _____

Anticipated D/C date and destination: _____

Specify supports recommended for D/C: _____

PROFESSIONALS/AGENCIES CURRENTLY INVOLVED WITH CLIENT (if known):

☐ Dietary
☐ Neurology
☐ NS Dept. of Health,
☐ Continuing Care
☐ Physiatry
☐ Psychology
☐ Social Work
☐ Vocational Counseling
☐ Neurosurgery
☐ NS Dept. of Community Services
☐ Occupational Therapy
☐ Physiotherapy
☐ Specialty Nurse Practitioner
☐ Speech Language Pathology
☐ Recreation Therapy
☐ Other (Specify) _____

REFERRALS SENT TO OTHER PROFESSIONALS/AGENCIES (e.g. neuropsychology, continuing care, etc)

Professional/Agency: _____ Date Referred: _____

Professional/Agency: _____ Date Referred: _____

SECTION B

Requesting Services of:

☐ **ABI Outreach**	☐ **ABI Day Program**	☐ **Coordinator - ABI Ambulatory Care Teams**
Provides support, education and consultation to service providers, families/caregivers and individuals living with ABI in the community setting within 25km of the Nova Scotia Rehabilitation Centre. ☐ ABI Education ☐ Cognitive Needs ☐ Perceptual Needs ☐ Community living skills i.e. transportation/banking ☐ Caregiver support/education ☐ Counselling/emotional support ☐ Self-care skills ☐ Functional mobility i.e. tranfers, fall prevention ☐ Facilitate connection to community support ☐ Behavior Managment ☐ Leisure education ☐ ABI Consultation for staff	Group based program located at the Nova Scotia Rehabilitation Centre that provides education and intervention to manage ABI symptoms and associated difficulties. Full and part-time program options available. ☐ ABI education ☐ Fatigue management ☐ Memory Strategies ☐ Leisure exploration and sampling ☐ Relaxation ☐ Emotional regulation ☐ Additional considerations impacting ability to attend daily treatment? (i.e. endurance; transportation; work schedules; other.) _____ _____	Through an intake process, identifies client needs, develops recommendations and evaluates the most appropriate ABI service to meet the clients and the families goals. ☐ Determine appropriate referrals and coordinate ABI ambulatory care services. ☐ Provide consultation to assist with complex discharge planning. ☐ Provide assistance locating exisitng community based services within Capital District Health Authority.

WHAT DO YOU HOPE TO ACHEIVE WITH THIS REFERRAL?_____

_____

CONSIDERATIONS/CONTRAINIDICATIONS (i.e., harmful involvement with substances, primary psychiatric diagnosis, seizures, behavorial patterns, dietary restrictions etc.)_____

_____

PRIMARY CONTACT PERSON Name: _____ Phone: _____

FORM COMPLETED BY (please print) _____ Phone: _____

PLEASE FAX FORM TO (902) 425-6574 **Coordinator - ABI Ambulatory Care Teams Tel: (902) 473-1186**