



**Acquired Brain Injury
OUTREACH, DAY PROGRAM, AND COORDINATOR - ABI AMBULATORY CARE TEAMS
REFERRAL FORM**

Fax to: 902-425-6574

SECTION A

Referral Date (YYYY/MON/DD): _____

Client Name: _____ Health Card Number: _____
(or affix patient label)

Primary Diagnosis: _____

Date (YYYY/MON/DD) and Cause of Acquired Brain Injury (ABI): _____

Relevant Past Medical History: _____

Is client aware of this referral? Yes No

Person to contact for appointment? Name: _____ Phone: _____

CURRENT LIVING STATUS

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

In hospital: Hospital name and unit: _____

Anticipated discharge date (YYYY/MON/DD): _____

and destination: _____

Specify supports recommended for discharge: _____

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

- | | |
|---|---|
| <input type="checkbox"/> Dietary | <input type="checkbox"/> Neurosurgery |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> NS Dept. of Community Services |
| <input type="checkbox"/> NS Dept. of Health | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Specialty Nurse Practitioner |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Speech Language Pathology |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Recreation Therapy |
| <input type="checkbox"/> Vocational Counselling | <input type="checkbox"/> Other (specify): _____ |

What do you hope to achieve with this referral? _____





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SECTION B

Requesting services of:

ABI Outreach

ABI Day Program

**Coordinator - ABI Ambulatory
Care Teams**

<p>Provides support, education and consultation to service providers, families/caregivers and individuals living with ABI in the community setting within NS Health Central Zone.</p> <ul style="list-style-type: none"> <input type="checkbox"/> ABI education <input type="checkbox"/> Cognitive needs <input type="checkbox"/> Perceptual needs <input type="checkbox"/> Community living skills i.e. transportation/banking <input type="checkbox"/> Caregiver support/education <input type="checkbox"/> Counselling/emotional support <input type="checkbox"/> Self-care skills <input type="checkbox"/> Functional mobility i.e. transfer, fall prevention <input type="checkbox"/> Facilitate connection to community support <input type="checkbox"/> Behaviour management <input type="checkbox"/> Leisure education <input type="checkbox"/> ABI consultation for staff 	<p>Group based program located at the Bedford Neuro Commons that provides education and intervention to manage ABI symptoms and associated difficulties.</p> <ul style="list-style-type: none"> <input type="checkbox"/> ABI education <input type="checkbox"/> Fatigue management <input type="checkbox"/> Memory strategies <input type="checkbox"/> Leisure exploration and sampling <input type="checkbox"/> Relaxation <input type="checkbox"/> Emotional regulation <input type="checkbox"/> Additional considerations impacting ability to attend daily treatment? (i.e. endurance; transportation; work schedules; other.) <p>_____</p> <p>_____</p> <p>_____</p>	<p>Through an intake process, identifies client needs, develops recommendations and evaluates the most appropriate ABI service to meet the client's and the family's goals.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Determine appropriate referrals and coordinate ABI ambulatory care services. <input type="checkbox"/> Provide consultation to assist with complex discharge planning. <input type="checkbox"/> Provide assistance locating existing community based services within NS Health Central Zone.
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Considerations/Contraindications (i.e. harmful involvement with substances, primary psychiatric diagnosis, seizures, behavioural patterns, dietary restrictions, etc.): _____

Form completed by (please print): _____ Position: _____

Signature: _____ Phone: _____

Please fax form to 902-425-6574.

Coordinator - ABI Ambulatory Care Teams Tel: 902-473-1186