

**SELKIRK MENTAL HEALTH CENTRE**  
*"We are a non-smoking facility"*



**ACQUIRED BRAIN INJURY  
PROGRAM REFERRAL FORM**

DATE: \_\_\_\_\_

**I. PERSONAL DATA**

Name: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

MB Health #: \_\_\_\_\_ PHIN #: \_\_\_\_\_

Legal Status:  Voluntary  Involuntary  
 Form 9 If yes, treatment decisions by: \_\_\_\_\_  
 Form 10

Previous admissions to Selkirk Mental Health Centre?  Yes  No

Order of Supervision  If yes, date issued: \_\_\_\_\_

Source of income: \_\_\_\_\_ Social Allowance # \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone (home): \_\_\_\_\_

Telephone (bus.): \_\_\_\_\_

**II. MEDICAL DATA**

Nature of head trauma/injury: \_\_\_\_\_

Onset date: \_\_\_\_\_ Previous admissions: \_\_\_\_\_

Present living situation: \_\_\_\_\_  
\_\_\_\_\_

Previous involvement in other community or hospital-based ABI Programs: \_\_\_\_\_

Indicate cooperation and response of client: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**II. MEDICAL DATA**-continued

*(significant medical history such as additional diagnoses, allergies, seizures, disabilities, etc.)*

Diet (please specify):

Swallowing Assessment Completed?

No  Yes (please attach)

Medications and Treatments *(include name, dosage and compliance)* :

Pneumococcal Vaccine given?

No  Yes \_\_\_\_\_  
Date

Mantoux Test Completed?

No  Yes \_\_\_\_\_  
Date

\_\_\_\_\_  
Reading

History of BCG?

No  Yes \_\_\_\_\_  
Date

**Pre-Injury Information**

Pre-injury living arrangements (i.e. with whom, type of setting, etc.):

Pre-injury vocational status:

Abilities/adaptive equipment required:

Interests:

Behavioural tendencies:

Alcohol/substance abuse:

Suicidal ideation:

#### **IV. SOCIAL DATA**

##### **Family Background**

Key relationships:

Family involvement with Client/Patient:

Family perceptions/expectations:

Other support systems:

Spiritual needs:

Education:

Employment/vocational history:

Financial resources:

Legal Issues:

##### **Rehabilitation Placements:**

Number and list all placements tried:

Duration of placement(s) and reason(s) for breakdown:

Current viable post-discharge placement option:

Patient/family post-discharge placement preference:

**V. REFERRAL SOURCE**

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_

What ABI Services are required: \_\_\_\_\_

Is the client/patient agreeable to ABI admission:  Yes  No

Is the family agreeable to ABI admission:  Yes  No

Date family consulted on ABI admission: \_\_\_\_\_

Does client/patient wish to tour ABI Program?  Yes  No

Does the family wish to tour ABI Program?  Yes  No

Community resource involvement?  Yes  No

Name: \_\_\_\_\_ Region: \_\_\_\_\_

Telephone: \_\_\_\_\_ Agency: \_\_\_\_\_

Please ensure the following are attached in order to assist the review teams with making a decision regarding the referral:

- 1. Significant medical history and reports including: physical exam, consultation reports, lab & diagnostic imaging reports (especially CT scans, MRIs of head), intensive care transfer summary, operative reports.
- 2. Neuropsychological/Psychological Reports
- 3. OT/PT/SLP Assessments

\_\_\_\_\_  
Signature of referring source

\_\_\_\_\_  
Date

**Please complete and forward to the appropriate program by mail (DO NOT FAX)**

Program Manager  
ABI Program  
Selkirk Mental Health Centre  
Box 9600  
Selkirk MB R1A 2B5