Selkirk Mental Health Centre
Acquired Brain Injury Rehabilitation Program Referral Form

Date:_____

Section 1: Personal Data:

Name:	Gender:
Language/s spoken:	Marital Status:
Date of Birth (month/day/year):	
MB Health #: PHIN #: Treaty #:	

Date of Injury or Event:	
Mechanism of Brain Injury (provide details with imaging) <u>Traumatic</u> <u>Non-traumatic</u>	

Applicant's address:	Accommodation: □ house □ apartment building □ supportive housing □ rooming house □ other (specify) _____
Phone:	

Section 2: Social Information

Next of Kin Name:	Relationship to Applicant: □ Spouse/Partner □ Parent □ Son □ Daughter □ Sibling □ Other

Address:	Phone (Home): Phone (Work):
E-mail:	Phone (Cell):
Enduring Power of Attorney (provide documentation) □ No □ Yes Private Committeeship (provide documentation) □ No □ Yes Order of Committeeship (Public Guardian and Trustee) □ No □ Yes	Advance Health Care Directives: □ No □ Yes (Specify): Third-Party involvement: □ MPI □ WCB □ Veteran's affairs □ Victims of Crime compensation □ INAC/FNIHB □ Other:

Contact Person (if different from next of kin):	
Name:	Phone (Home):
Relationship to Applicant:	Phone (Work):
E-mail:	Phone (Cell):

Education/Employment	
Highest Grade/Level Attended:	Employed at Time of Injury or Event: □ No □ Yes
When:	Type and Duration of Employment:
Legal Issues/ Involvement with justice system:	

Section 3: Referral Source

Contact Name/Position:	Applicant is currently: □ in hospital □ at home □ long-term care (LTC) □ other (specify) _____
Organization:	
Phone:	If applicant is in hospital/ LTC, please provide:
Other Phone:	Date of admission: _____ Planned date of discharge: _____

1. Reason(s) for Referral

_____

_____

_____

_____

2. Patient/Decision maker consents to referral and release of information: □ Yes
3. Is the patient agreeable to ABI admission? □ No □ Yes
   If no, why not?

   _____

4. Is the family agreeable to ABI admission? □ No □ Yes
   If no, why not?

   _____

   Date family consulted regarding admission _____

5. Does the patient wish to tour ABI program? □ No □ Yes
6. Does the family wish to tour ABI program? □ No □ Yes

Section 4: Medical Information

Please have each question completed by appropriate discipline if available.

1. Past Medical / Psychiatric History

2. Does applicant have any allergies?
   □ No
   □ Yes

   If yes, please indicate the allergies and reaction.

3. Seizures
   □ No
   □ Yes

   If yes, please include dates and description:

4. CT/MRI Results (or attach report)
   Please include the date of completion and facility.

5. Past consultations or assessments (provide documentation)

6. Substance use / Addiction (including alcohol, cannabis and nicotine)
   □ History Specify:
   □ Current Specify:
   □ Unknown

7. Does the patient use a CPAP machine? □ No □ Yes

8. Please list **all** current medications and reasons for taking them (attach MAR):

Medication	Reason

9. Vaccinations:
   a. Influenza Vaccine up to date? Date: _____
   b. Pneumococcal Vaccine up to date? □ No □ Yes
      Date: _____
   c. COVID-19? Date: _____
   d. Tetanus vaccine up to date? Date: _____
   e. History of Bacillus Calmette G? □ No □ Yes

      Date:_____
   f. Mantoux Test Completed? □ No □ Yes

      Reading: _____ Date: _____

10. Primary health care provider:

11. Previous admissions to other hospitals or psychiatric facilities:

12. Pending medical appointments:

Section 5: Service Information
Please have each question completed by appropriate discipline, if available.

1. Has the patient received previous rehabilitation? □ No □ Yes
2. Is the patient currently receiving rehabilitation services? □ No □ Yes
   If yes, please indicate the services that were/are received:

	Dates	Location
Occupational Therapy	_____	_____
Physical Therapy	_____	_____
Speech-Language Pathology	_____	_____
Neuropsychology	_____	_____
Other	_____	_____

3. Describe the patient's level of participation in the above services. Include how many sessions per week per therapist and how long the sessions were/are.

_____

_____

_____

4. List of mobility/gait aids used prior to brain injury:

_____

_____

Section 6: Functional Information
Please place a check mark to indicate the applicant's current level of functioning at time of referral (see definitions in box below). Please comment on any adaptive equipment applicant requires/utilizes.

Definitions:
Independence (I): able to complete task safely in a reasonable amount of time without assistance
Modified Independence (MI): able to complete a task with help (e.g., device) and with more time
Supervision (S): able to complete task with supervision/verbal cueing without physical assistance
Minimal assistance (MiA): able to complete task with 25% physical assistance
Moderate assistance (MoA): able to complete task with 50% physical assistance
Maximal assistance (MaA): requires more than 50% physical assistance to complete task
Total assistance (TA): total physical assistance is required to complete task

Activities of daily living / Instrumental Activities of daily living

Activity	I	MI	S	MiA	MoA	MaA	TA	Comments
Eating/Drinking								
Dressing (upper body)								
Dressing (lower body)								
Toileting								
Bathing/Showering								
Grooming								
Medication Administration								
Meal Preparation								
Housekeeping								
Shopping								
Financial Management								

Mobility/Locomotion

Activity	I	MI	S	MiA	MoA	MaA	TA	Comments
Transfers - chair								
Transfers - bed								
Transfers - wheelchair								
Transfers - vehicle								
Transfers - toilet								
Transfers – tub or shower								
Floor transfer								
Walking								
Wheelchair								
Stairs								With rails: ☐ Yes ☐ No
Outdoor/community mobility								

Falls/History of falls:
☐ Yes ☐ No
Stamina:
☐ Good ☐ Poor
Balance/dizziness:
☐ Yes ☐ No
Mobility Aids:
☐ Yes ☐ No If yes, describe:
Own aids:
☐ Yes ☐ No

Behaviors (please comment on the following)

Ability to adjust to change:

Impulsivity:

AWOL risk:
Aggression:
Sexual:
Suicidal risk/ideation:
Other:

Cognition (please comment on the following)

Orientation:
☐ Time ☐ Person ☐ Place
Initiation:
Safety & judgment:
Problem-solving skills:
Memory:
Attention:
Follows instructions:
☐ 1 step ☐ 2 step ☐ 3 step
Frustration tolerance:
Insight:
Perception:

Communication

Vision:
Has a recent assessment been completed? ☐ Yes ☐ No
☐ Within Normal Limits ☐ Impaired ☐ Severely impaired
Comments:
Glasses: ☐ Yes ☐ No

Hearing:
☐ Within Normal Limits
Impaired: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

☐ Right ☐ Left
Hearing aid(s): ☐ Yes ☐ No

SLP Assessment completed (Attach report)
☐ Yes ☐ No

Describe communication:

Trial/use of Augmentative and Alternative Communication (AAC): ☐ Yes ☐ No

Bowel and Bladder

Bowel: ☐ Continent ☐ Incontinent
Bladder: ☐ Continent ☐ Incontinent

Sleep/Wake Cycle

Experiences fatigue during the day:
☐ Yes ☐ No If yes, when:
Sleep disturbances:
☐ Yes ☐ No If yes, please explain:

Swallowing/Diet Information

Means of nutrition:
☐ Oral ☐ Non-oral (specify type):

Diet Texture/Fluid consistency:

Has a swallowing assessment been completed? ☐ Yes ☐ No

If yes, please indicate when the swallowing assessment was completed and the outcome:

Section 7: Patient/Family Goals & Services Requested

1. What ABI services are being requested?
   a. Occupational Therapy ☐ No ☐ Yes
   b. Physical Therapy ☐ No ☐ Yes
   c. Speech Language Pathology ☐ No ☐ Yes
   d. Neuropsychology ☐ No ☐ Yes
   e. Social Work ☐ No ☐ Yes
   f. Therapeutic Recreation ☐ No ☐ Yes
   g. Other (please specify) _____

2. What are the patient's self-identified goals?

3. What are the family's goals for the patient?

4. Describe the level and nature of family involvement?

Section 8: Discharge

1. Current viable post-discharge option/location.

2. Patient/family post-discharge placement preference.

3. List other discharge sites attempted/referred to (include dates) and the outcome.

Attachments:
Ensure the following are *attached* in order to assist the intake team with making a decision.

a. Physical Examination
b. Consultation Reports
c. Laboratory & Diagnostic Imaging Reports (including CT scans, MRIs of head)
d. Intensive Care Transfer Summary
e. Operative Reports/ER report w/GCS
f. Neuropsychological/Psychological Reports
g. Admission OT/PT/SLP Assessments/Reports
h. Current OT/PT/SLP Assessment/Reports
h. Social History

Other Comments:

_____

_____

_____

_____

_____

_____ _____

Signature of Source/Designation Date

Please forward referral and other documentation by mail. Upon receipt of this referral package, the ABI Intake team will review the package and determine if the applicant is eligible for the SMHC ABI Program. The referral source will then be contacted for a follow up appointment with the ABI Intake team, or will receive notification that the applicant is not an eligible candidate for the ABI Program at this time.

Please complete and forward to the ABI Program Manager via fax to 204-785-1507.
Forward original in mail to:

Program Manager
ABI Program
Selkirk Mental Health Centre
Box 9600, 825 Manitoba Avenue
SELKIRK MB R1A 2B5

Questions/Inquiries please contact the Program Manager 204-482-1616.