



TBI ADULT PROFILE (16yrs. +)
 (Choose the category (Adult/Child) which best meets the client's needs)

Demographic Information - Optional

For office use only - Client ID # _____

(Please PRINT in ink) Mandatory Information (this section only)		
Client's Name: (Last) _____	(First) _____	Date of Birth: (Y)____/(M)____/(D)____

Home Address

Street: _____ **City:** _____

Postal Code: _____ **Telephone:** () _____

Email: _____ **Fax:** () _____

Present Home Living Situation: alone with others (specify): _____

Present Accommodation: house residential group home apartment other: _____

Date of Injury: (Y)____/ (M)____/(D) ____ **Was the Injury Work Related?** no yes

Nature/Type of Injury:
 mva (motor vehicle) mca (motocycle) ATV fall assault sporting other: _____

Family Physician

Name: _____ **Telephone:** () _____

Address: _____ **Fax:** () _____

_____ **Email:** _____

This page completed by (Print Name): _____	Date: (Y) : (M) : (D)
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This information contained herein is confidential and no unauthorized person will have access to the information without the consent of the client or substitute decision-maker. **Page 1 / 5**

Please send or fax the completed TBI Client Referral to
 TBI Clinical Coordinator/Educator, TBI Centralized Coordination and Referral Tracking Office
 c/o The Rehabilitation Centre • 505 Smyth Road • Rm. 2502 • Ottawa • ON • K1H 8M2
 Phone: 737-7350 ext. 5243 Fax: 739 – 3273



TBI ADULT PROFILE (16yrs. +)

Choose the category (Adult/Child) which best meets the client's needs.

Social Information – Optional

For office use only - Client ID #

(Please PRINT in ink)

Mandatory Information (this section only)

Client's Name: (Last) _____ (First) _____ Date of Birth: (Y)____/(M)____/(D)____

Power of Attorney	<input type="checkbox"/> n/a	
<input type="checkbox"/> financial	name:	phone:
<input type="checkbox"/> personal care	name:	phone:

Guardian (if applicable)	<input type="checkbox"/> n/a	
<input type="checkbox"/> financial	name:	phone:
<input type="checkbox"/> personal care	name:	phone:

Public Guardian and Trustee:	<input type="checkbox"/> n/a	
<input type="checkbox"/> financial	name:	phone:
<input type="checkbox"/> personal care	name:	phone:

Substitute Decision-Maker	<input type="checkbox"/> n/a	
Relationship to Client:	<input type="checkbox"/> spouse/partner <input type="checkbox"/> parent <input type="checkbox"/> sibling <input type="checkbox"/> daughter <input type="checkbox"/> son <input type="checkbox"/> other _____	
Name:	Street Address:	
City & Prov.:	Postal Code:	
Phone at Work:	Phone at home:	

Contact Person (if different from substitute decision-maker)	<input type="checkbox"/> n/a	
Relationship to Client:	<input type="checkbox"/> spouse/partner <input type="checkbox"/> parent <input type="checkbox"/> sibling <input type="checkbox"/> daughter <input type="checkbox"/> son <input type="checkbox"/> other _____	
Name:	Street Address:	
City & Prov.:	Postal Code:	
Phone at Work:	Phone at home:	

Capacity Assessment completed? n/a No Yes

If Yes, Result: capable incapable Service Provider (name): _____ Date: (Y) __/(M) __/(D) __

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Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Client:
If yes: Name _____	<input type="checkbox"/> professional service <input type="checkbox"/> spouse/ partner
Address: _____	<input type="checkbox"/> parent <input type="checkbox"/> sibling
City/Prov.: _____ Postal Code: _____	<input type="checkbox"/> daughter <input type="checkbox"/> son
Phone (Work): _____ (Home): _____	<input type="checkbox"/> other _____

Financial Information: (check all that apply)	<input type="checkbox"/> WSIB <input type="checkbox"/> CPP <input type="checkbox"/> STD <input type="checkbox"/> Auto Insurance
	<input type="checkbox"/> LTD <input type="checkbox"/> Private Insurance <input type="checkbox"/> OW <input type="checkbox"/> No income
	<input type="checkbox"/> ODSP <input type="checkbox"/> OAS <input type="checkbox"/> Other _____

Employed at time of injury? Yes No

Transportation (check all that apply) Mode of transportation for attending program/service:
 Para/ Accessible Transpo OC/ Public Transpo School Board Bus Private Family Self Other

Education	
<input type="checkbox"/> In school	Present grade: _____
	School name: _____
	Contact Person: _____ Phone: _____
<input type="checkbox"/> No longer in school	Highest level completed: <input type="checkbox"/> Grade school <input type="checkbox"/> University <input type="checkbox"/> High school <input type="checkbox"/> Post Graduate <input type="checkbox"/> College

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TBI ADULT PROFILE (16yrs. +)
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Medical Information – Optional

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(Please PRINT in ink)	Mandatory Section	
Client's Name: (Last) _____	(First) _____	Date of Birth: (Y)____/(M)____/(D)____

Primary Diagnosis:	
Secondary Diagnosis:	

Glasgow Coma Score on admission:	<input type="checkbox"/> not available	<input type="checkbox"/> 15	<input type="checkbox"/> 13-14	<input type="checkbox"/> 9-12	<input type="checkbox"/> ≤8		
Loss of consciousness:	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <10 min.	<input type="checkbox"/> 10-30 min.	<input type="checkbox"/> 30 min. – 6 hrs.	<input type="checkbox"/> >6 hrs.
Post Traumatic Amnesia:	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <10 min	<input type="checkbox"/> <24 hrs	<input type="checkbox"/> 1-14 day	<input type="checkbox"/> > 14 days
Seizures:	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not known	If yes, is it controlled with medication? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not known			

Does individual have / had MRSA:	<input type="checkbox"/> current	<input type="checkbox"/> past	<input type="checkbox"/> no	<input type="checkbox"/> not known
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Definition of MRSA: Methicillin-resistant staphylococcus aureus (drug resistant organism)

Does individual have / had VRE:	<input type="checkbox"/> current	<input type="checkbox"/> past	<input type="checkbox"/> no	<input type="checkbox"/> not known
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Definition of VRE: Vancomycin-resistant enterococcus (drug resistant organism)

Allergies	
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Current Service Provider Involvement			
Agency and Provider Names	Type of Care or Service	Phone	Specifics

List of Current Medications			
Name of Meds	Dosage	Reason	Date Prescribed

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TBI ADULT PROFILE (16yrs. +) Medical Information cont'd.

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TBI Assessments History (enter most recent at the bottom of the list)				
Facility and/or Provider Name	City/Town	Phone	Date	Provider Type/Discipline

TBI Treatment History (enter most recent at the bottom of the list)						
Facility	Provider Name	Type of Care/Service	City/Town	Phone	Admission Date	Discharge Date

Other Relevant Health/Medical History		
Specify	Date	Intervention

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