



ADULT REFERRAL INFORMATION (16yrs. +)

REFERRAL DESTINATION: INPATIENT STAY / REHABILITATION

(For Youth 16 – 18 years of age, choose the category (Child/Adult) which will best meet their needs.)

Referring Service Provider to Complete

Client's Name(Last)_____ (First)_____	Date of Birth(Y)____/(M)____/(D)____
Client's Current Location: _____	Phone #: _____
Expected Discharged Date : (Y)____/(M)____/(D)_____	

Referral Destination: CHECK ONLY ONE REFERRAL DESTINATION

- Pembroke General Hospital (Generic Rehab Unit)
- Elisabeth Bruyère (Brain Injury Rehab Unit)
- The Rehabilitation Centre (Behaviour Rehabilitation Services)
- Name of Acute Care/Complex Continuing Care Hospital (No Rehab Unit) / Other facility: _____

Reason for Referral: Check all that apply

Inpatient rehab		Inpatient stay	
<input type="checkbox"/> Physical Assessment	<input type="checkbox"/> Cognitive Assessment	<input type="checkbox"/> Assessment	<input type="checkbox"/> Surgery
<input type="checkbox"/> Behavioural Assessment	<input type="checkbox"/> Treatment/Therapy	<input type="checkbox"/> Medication Review/Management	<input type="checkbox"/> Waiting Placement
		<input type="checkbox"/> Treatment/Therapy	

Please complete and include with referral the most recent outcome measures: FIM n/available MPAI n/available

* Mandatory Response Required: You must provide either an e-mail address [preferable], or fax #.

I authorize a referral to this facility / agency / provider as specified:			
*From (Facility):		*To (Facility):	
*Contact Name:		Contact Name:	
*Phone:	Fax:	*Phone :	Fax:
Email:		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.

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



ADULT REFERRAL CONFIRMATION (16yrs. +)

Receiving Service Provider To Complete

Return by fax to the address below within 2 days

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

Intake Process	
Planned date of assessment/consult:	(Y) ____/(M) ____/(D)____ <input type="checkbox"/> N/A
Actual date of assessment/consult:	(Y) ____/(M) ____/(D)____ <input type="checkbox"/> N/A
Accepted by Receiving Service Provider:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Planned date of admission:	(Y) ____/(M) ____/(D)____
If no, check reason: <input type="checkbox"/> Physical Needs <input type="checkbox"/> Medical Needs <input type="checkbox"/> Cognitive Needs <input type="checkbox"/> Behavioural Needs <input type="checkbox"/> Other	
Comment:	

***Mandatory Response Required (You must provide either [preferably] an e-mail address or fax #)**

*Name of Receiving Service Provider:	*Name of Organization:
*Phone:	*E-mail:
	*Fax:

Complete when known

Client Acceptance: Yes No

If no, give reason:

Actual Date of Admission/assessment: (Y) ____/(M) ____/(D)____

This page completed by (Print Name):	Date:	(Y)	(M)	(D)
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TBI INTEGRATION PROJECT - OFFICE USE ONLY

Date referral received: (Y)____/(M)____/(D)____ **Date referral reviewed:** (Y)____/(M)____/(D)____

Reviewer: _____

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 C/o The Rehabilitation Centre • 505 Smyth Road • Rm. 2502 • Ottawa • ON • K1H 8M2
 Phone: 737-7350 ext. 5243 Fax: 739-3273



ADULT REFERRAL INFORMATION (16yrs. +)

REFERRAL DESTINATION: COMMUNITY / AMBULATORY (All “non inpatient)

Referring Service Provider to Complete

Client's Nam (Last) _____ (First) _____	Date of Birth(Y) ____/(M) ____/(D) ____
Client's Current Location: _____	Phone #: _____
Expected Discharged Date : (Y) ____/(M) ____/(D) ____	

Referral Destination: COMPLETE ONE REFERRAL FORM PER DESTINATION

<input type="checkbox"/> Boarding Home (Supported Living Services)	<input type="checkbox"/> Private Provider - Specify contact & email: _____
CCAC: <input type="checkbox"/> Ottawa <input type="checkbox"/> Renfrew County <input type="checkbox"/> 5 Eastern Counties	<input type="checkbox"/> Retirement Home - Specify contact & email: _____
<input type="checkbox"/> City of Ottawa ABI Program	<input type="checkbox"/> The Rehabilitation Centre: BRS Outreach
<input type="checkbox"/> Head Injury Association (Ottawa-Valley)	<input type="checkbox"/> The Rehabilitation Centre: Outpatient Clinic
<input type="checkbox"/> Home Health Services – Specify: _____	The Robin Easey Centre:
<input type="checkbox"/> March of Dimes	<input type="checkbox"/> Day Program or <input type="checkbox"/> Outreach Program <input type="checkbox"/> Residential
<input type="checkbox"/> Nursing Home – Placement Coordination Service	<input type="checkbox"/> The Ottawa Hospital – Outpatient
<input type="checkbox"/> Ontario Disability Support Program (ODSP)	<input type="checkbox"/> WSIB
<input type="checkbox"/> Pathways to Independence	<input type="checkbox"/> Vista Centre
<input type="checkbox"/> Pembroke General Hospital Outpatient	<input type="checkbox"/> Other - Specify: _____

Reason for Referral: Check all boxes that apply

Behavioural Rehabilitation <input type="checkbox"/> Assessment <input type="checkbox"/> Education <input type="checkbox"/> Treatment/Behaviour Management	Caregiver/Peer Support <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group	<input type="checkbox"/> Case Management
Clinical Dietitian <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Life Skills Training <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment/Training	Long Term Living <input type="checkbox"/> 24 hour care and supervision
Medical Specialist <input type="checkbox"/> Assessment/Consult <input type="checkbox"/> Treatment <input type="checkbox"/> Medication Review <input type="checkbox"/> Follow- Up	Nursing <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Occupational Therapy <input type="checkbox"/> Driving Assessment <input type="checkbox"/> Equipment <input type="checkbox"/> Functional Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education
Physiatry <input type="checkbox"/> Assessment/Consult <input type="checkbox"/> Treatment <input type="checkbox"/> Medication Review <input type="checkbox"/> Follow- Up	Physiotherapy <input type="checkbox"/> Assessment <input type="checkbox"/> Education <input type="checkbox"/> Treatment	Psychology <input type="checkbox"/> Assessment(neuropsychological) <input type="checkbox"/> Education <input type="checkbox"/> Assessment (mood) <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Treatment
Recreational Day Program <input type="checkbox"/> Social Reintegration <input type="checkbox"/> Fitness/Leisure	Respite Care <input type="checkbox"/> In-Home <input type="checkbox"/> Out of Home	Social Work <input type="checkbox"/> Individual Assessment <input type="checkbox"/> Individual Counseling <input type="checkbox"/> Family /Couple Assessment <input type="checkbox"/> Family counseling/ Support/Education <input type="checkbox"/> Resources
Speech Language Pathology <input type="checkbox"/> Cognitive Communication Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Supportive Independent Living <input type="checkbox"/> Attendant Care <input type="checkbox"/> Home Support <input type="checkbox"/> Activities of Daily Living	
Transitional Living <input type="checkbox"/> Cognitive Assessment <input type="checkbox"/> Education <input type="checkbox"/> A.D.L./Self Care Assessment <input type="checkbox"/> Treatment/Training/Therapy	Vocational Rehabilitation <input type="checkbox"/> Assessment <input type="checkbox"/> Liaison/Resources <input type="checkbox"/> Assistance with Job Readiness	Other: (Specify)

This page completed by (Print Name): _____	Date: (Y) ____ ; (M) ____ ; (D) ____
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ADULT REFERRAL INFORMATION (16yrs. +)

REFERRAL DESTINATION: COMMUNITY / AMBULATORY(All “non inpatient) con’t..

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

Complete and include with referral the most recent outcome measures: The Return to Normal Living Index not available

* Mandatory Response Required: You must provide either an e-mail address [preferable], or fax #.

I authorize a referral to this facility / agency / provider as specified:	
*From (Facility):	*To (Facility):
*Contact Name:	Contact Name:
*Phone: _____ Fax: _____	*Phone : _____ Fax: _____
Email: _____	Email: _____

This page completed by (Print Name): _____	Date: (Y) _____ (M) _____ (D) _____
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