



CHILD/YOUTH PROFILE – (<18 yrs.)

Please select the profile category for the client which is between 16 to 18 (Adult vs Child) which is of most advantageous to the client.

Demographic Information – Optional

For office use only 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: _____ **Telephone:** () _____

Postal code: _____ **Fax:** () _____

Email: _____

Present Home Living Situation: with parent(s) with others (specify): _____

Present Accommodation: house apartment
 residential group home other: _____

Date of Injury:

<i>Year</i>	<i>Month</i>	<i>Day</i>

Nature/Type of Injury: mva (motor vehicle) assault
 mca (motorcycle) sporting
 fall 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



CHILD/YOUTH PROFILE (<18 yrs.)

Social Information - Optional

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(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:

Decision-Maker <input type="checkbox"/> n/a		
Relationship to Client:	Name:	
<input type="checkbox"/> parent <input type="checkbox"/> sibling <input type="checkbox"/> other	Address:	
Postal Code:	Work Phone #:	Home Phone #:

Contact Person (if different from substitute decision-maker)		
<input type="checkbox"/> n/a		
Relationship to Client:	Name:	
<input type="checkbox"/> parent <input type="checkbox"/> sibling <input type="checkbox"/> other	Address:	
Postal Code:	Work Phone #:	Home Phone #:

Capacity Assessment completed?	<input type="checkbox"/> n/a <input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Result: <input type="checkbox"/> capable <input type="checkbox"/> incapable	Service Provider (name): _____ Date: ____/____/____ <i>year/month/day</i>

Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Client: <input type="checkbox"/> professional service <input type="checkbox"/> parent <input type="checkbox"/> sibling <input type="checkbox"/> other _____
If yes: name	
address:	
Postal Code:	
Work Phone #:	
Home Phone #: (family members only):	

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CHILDREN/YOUTH PROFILE (<18 yrs.)

Social Information - con't.

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

Education	
<input type="checkbox"/> Preschool	Name of Preschool: _____ Contact Person: _____ Phone #: _____
<input type="checkbox"/> In school	Present grade: _____ School Board: _____ School name: _____ Contact Person: _____ Phone #: _____
<input type="checkbox"/> No longer in school	Highest level completed: <input type="checkbox"/> elementary school <input type="checkbox"/> secondary school <input type="checkbox"/> other

Employed at time of injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Financial/Funding Information: (check all that apply)	<input type="checkbox"/> Auto Insurance	<input type="checkbox"/> The Easter Seal Society
	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Ontario Works
	<input type="checkbox"/> ACSD	<input type="checkbox"/> Service Coordination
	<input type="checkbox"/> Special Services at Home	<input type="checkbox"/> No income
	<input type="checkbox"/> CCAC	<input type="checkbox"/> Other (Specify): _____

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

Family/support network information			
Name	Relationship	Level of involvement	Type of involvement

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CHILDREN/YOUTH PROFILE (<18 yrs.)

Medical Information – Optional

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

Primary Diagnosis:	
Secondary Diagnosis:	

Glasgow Coma Score on admission: not available 15 13-14 9-12 ≤8

Loss of consciousness: not available <10 min. 10-30 min. 30 min. – 6 hrs. >6 hrs.

Post Traumatic Amnesia not available <10 min. <24 hrs. 1-14 days > 14 days

Seizures: yes no not known If yes, is it controlled with medication? yes no not known

Does individual have or has had MRSA: current past no not known

Definition of MRSA: Methicillin-resistant staphylococcus aureus (drug resistant organism)

Does individual have or has had VRE: current past no not known

Definition of VRE: Vancomycin-resistant enterococcus (drug resistant organism)

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

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

Other Relevant Health/Medical History		
Specify	Date	Intervention

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