Brain Care Centre®
Defy Limitations!

#305, Hys Centre, 11010-101 Street NW, Edmonton, Alberta T5H 4B9
Tel. (780) 477-7575 Fax (780) 474-4415 www.braincarecentre.com

# Referral for Brain Care Centre (BCC) Services
# Self-Referral Form


**Date of Referral:**

| Month | Day | Year |
|---|---|---|
| | | |

Are you **PDD (Persons with Developmental Disabilities)** funded?

☐ Yes → You are **not eligible** for BCC services


☐ No → **Continue**

## 1. About You


**Name:**

| First Name | Last Name |
|---|---|
| | |

**Date of Birth:**

| Month | Day | Year |
|---|---|---|
| | | |


**Personal Health Number:**

| | | | | | - | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

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**Address:**

| | |
|---|---|
| Address | |
| City | Province |
| Postal Code | |
| Group Home: ☐<br>Facility: ☐ | |

Have you ever been a client of:

☐ ebirs Edmonton Brain Injury Relearning Society

☐ NABIS BRAIN INJURY SOCIETY

☐ Brain Care Centre® Defy Limitations!

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## Contact Information:

| Phone (Home) | Phone (Cell) |
|---|---|
| Email | |
| Special considerations:<br>☐ Prefer email<br>☐ Work full-time<br>☐ English as second language (ESL)<br>☐ Communication difficulty (e.g. aphasia) | |

## Alternate Contact:

| Name |
|---|
| Relationship |
| Phone |
| Comments |

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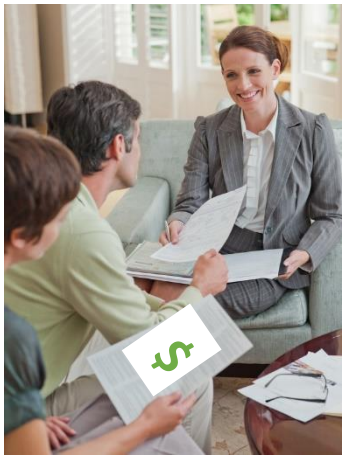
# 2. Alternative Decision-Making Information (if applicable)

| **Guardian**<br>☐ Private<br>☐ Co-Decision Making<br>☐ Supported Decision Making<br>☐ Public | Name<br><br>Phone |
|---|---|



| **Trustee**<br>☐ Private<br>☐ Public | Name<br><br>Phone |
|---|---|

| **Other**<br>☐ Power of Attorney<br>☐ Personal Directive | Name<br><br>Phone |
|---|---|

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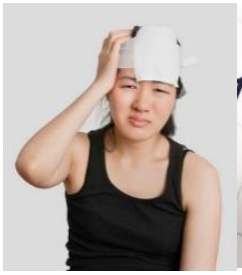
# 3. History of Acquired Brain Injury

**Acquired** brain injury means **damage to the brain** which:

- Occurs **after birth**
- **Not related** to congenital or degenerative disease




**When** was your brain injury?

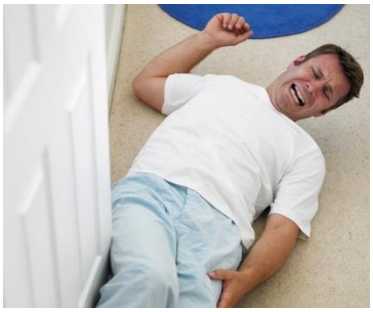
| Month | Day | Year |
|---|---|---|
| | | |

**How** did your brain injury happen?

☐ Assault

☐ Car accident

☐ Fall



☐ Sports

☐ Stroke

☐ Substance use

☐ Other: _____

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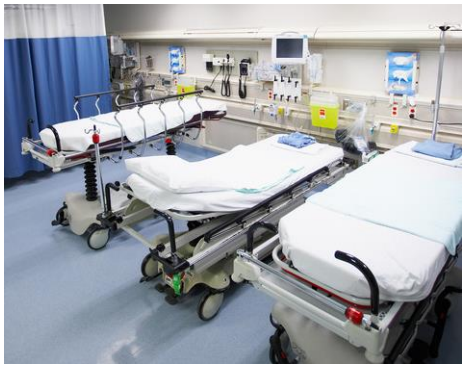
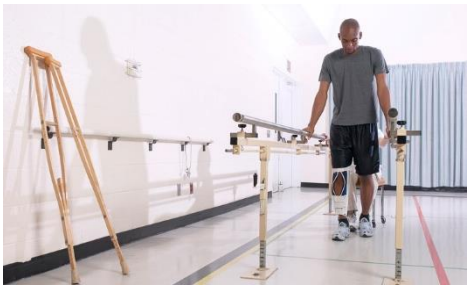
**Severity** of injury (please **circle**):


**Hospital** of admission and dates (if known):



| Hospital | Date |
|---|---|
| Hospital | Date |

**Rehabilitation** received and dates (if known):



| Facility | Date |
|---|---|
| Facility | Date |
| Facility | Date |

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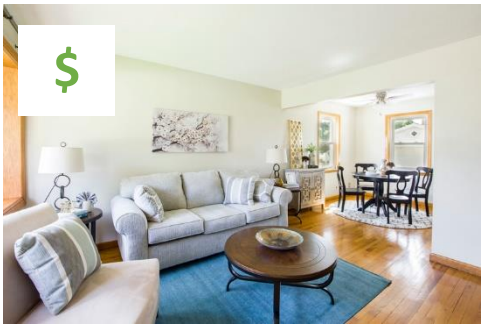
# 4. Community/Social Support

What **services** do you **have** in place **now**?

☐ Homecare

☐ Housing subsidy




☐ Financial assistance

☐ Transportation


☐ Other: _____

I have **help** from:

☐ Family

☐ Friends

☐ Other: _____

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# 5. Medical Support

| | | |
|---|---|---|
| **Family Doctor** | Name | |
| | Phone | Fax |
| | Email | |
| **Other:** _____ | Name | |
| | Phone | Fax |
| | Email | |
| **Other:** _____ | Name | |
| | Phone | Fax |
| | Email | |

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Please comment on any other **medical** or **health concerns**:

☐ Diabetes ☐ Cancer

☐ Heart condition ☐ Depression

☐ Seizures ☐ Anxiety

☐ Epilepsy ☐ PTSD

☐ Other: _____

_____

_____

Do you have a **history** of:

☐ Substance use ☐ Criminal charges ☐ Violent behaviour

If any of these boxes are checked:

- **Further information** must be provided
- Attach **additional documents** if required

This information is collected to ensure the **safety** of our staff and **the best outcome** for our clients.

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# 6. Required Support

## I need **help** with…

☐ Housing

☐ Finances

☐ Transportation


☐ Counseling

☐ Independent living

☐ Socialization

☐ Support Group

☐ Assistive Device Training

☐ Leisure Access

☐ Other: _____

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# 7. Medical Documentation

To be **eligible for service**, we require medical documentation of an **acquired brain injury**.

**Example:**

- Neuropsychological assessment
- Discharge summary
- CT scan
- MRI scan
- Diagnosis from medical doctor

Please **choose one**:

☐ I have **attached** medical documentation

☐ I **need assistance** getting medical documentation

Hospital: _____

**OR** Doctor: _____

Contact: _____

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# Submit Your Referral

**Choose one** of:

| | |
|---|---|
| **Mail**  | Brain Care Centre<br>#305, Hys Centre<br>11010 – 101 Street NW<br>Edmonton, AB T5H 4B9 |
| **Fax**  | 780-474-4415<br>Attention: New Referral |
| **Email**  | info@braincarecentre.com |

**All areas** of referral form must be **completed**.

**Incomplete** referrals will be **sent back**.

**Referrals** and medical documentation will be **kept for 1 year.** If no contact, it will be destroyed.

By submitting this form, you **agree** that we may keep **confidential** and **secure** files with your information.