

Referral for Brain Care Centre (BCC) Services

Individual with Acquired Brain Injury* Information

(*acquired brain injury means damage to the brain which occurs after birth and is not related to congenital or degenerative disease)

First Name	Last Name			Date of Birth		
Address- Please note if this is a facility or group home						
City	Province			Postal Code		
Phone - Home	Phone- Cell			Health Care Number		
Email						
Special considerations when contacting (e.g. prefers email, works full-time, ESL, has expressive speech delay, aphasia or other communication difficulties, best person to contact, etc.)						
Alternate Contact Name	Relationship		Phone	Comments		
Have you ever been a BCC, NABIS (Northern AB Brain Injury Society) or EBIRS (Edmonton Brain Injury Relearning Society) client before? Ves No						
Alternative Decision-Making Information (if applicable)						
Guardian □ Private		Guardian Name				
□ Co-Decision Making□ Supported Decision Making□ Public		Phone				
Trustee (Do you make your own financial decisions?) Private Public		Trustee Name				
		Phone				
Other (Enduring Power of Attorney, Personal Directive)		Name				
		Phone				
Is the individual PDD funded?						
 ☐ Yes ☐ No If yes, person is not eligible for Brain Care Centre services.						

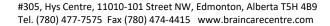


History of Acquired Brain Injury*

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Date of Incident			Severity of Injury (For mild injuries please use "Referral for Post- Concussion Services" form)		
Event Description		Type of Injury (i.e.,	Type of Injury (i.e., stroke, tumor, hematoma, etc.)		
Hospital of Admission and dates if known		Rehabilitation Supp	Rehabilitation Supports Received and dates if known		
Community/Social Support					
List any services/supports currently in place (e.g. Homecare, housing subsidy, financial assistance, transportation, etc.)					
Please comment on family and/or natural supports					
Medical Support					
Family Doctor	Phone	Fax	Email		
Medical Practitioner/Speciality	Phone	Fax	Email		
Other Medical Specialist	Phone	Fax	Email		
Please comment on any other medical or health concerns (e.g. diabetes, heart condition, seizures, mental health conditions, etc.)					
Is there a history of: ☐ Substance use		If any of these boxes are checked, further information <i>must</i> be provided. Attach additional documents if required**			
☐ Criminal charges					
□ Violent behaviour					
**This information is collecte	d to ensure the safety of our	staff and the best out	come for our clients		

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Required Support

Please indicate supports/services required					
Medical Documentation of Acquired Brain Injury					
Before an individual is eligible for service, BCC requires medical documentation of the acquired brain injury. As Brain Care Centre does not have access to NetCare, please send medical documentation on file. This can include (but is not limited to): a neuropsychological assessment, discharge summary, CT scan or MRI with interpretation of results, diagnosis from medical doctor, rehabilitation reports, etc. Attached Need assistance obtaining medical documentation*** ***Please note hospital(s) admission(s)/specialist(s) name and contact information/family doctor and contact					
information if you are not able to provide medical documentation and will need assistance obtaining it:					
Referral Completed By (Please print name)	Relationship (if not a self-referral)				
Phone	Fax				
Email	Date				

Mail to address at the top of the form, fax to **780-474-4415 (attention: New Referral)**, or email info@braincarecentre.com

All areas of referral form **must** be completed or the referral will be deemed incomplete and sent back to the referral source. Referrals and medical documentation will be kept for 1 year after which it will be confidentially destroyed if no follow through or contact.

By submitting this form you agree that we may keep confidential and secure files with your information, both in paper form and in electronic form on a secure database.