Head Injury Rehabilitation Ontario

MEDICAL STATUS FORM

Tel: 905-523-8852 ext. 123 **Fax:** 905-523-8211
Email: admissions@hiro.ca **Web:** www.hiro.ca

TO BE COMPLETED BY **PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER**

The following person has applied to Head Injury Rehabilitation Ontario:

_____ _____/_____/_____

First Name Last Name Date of Birth (MM/DD/YYYY)

_____ _____

Address Street City Postal Code Unit # Phone Number

Is the applicant's diagnosis an acquired brain injury? ☐ Yes ☐ No

If no, please specify the diagnosis: _____

Is the brain injury progressive or degenerative in nature? ☐ Yes ☐ No

If yes, ☐ Alzheimer's Disease ☐ Dementia ☐ Other; please specify _____

Does the applicant have an intellectual disability? ☐ Yes ☐ No

If yes, please specify: _____

Does the applicant have a mental health diagnosis? ☐ Yes ☐ No

If yes, please specify: _____

Currently, does the applicant have substance use issues? ☐ Yes ☐ No

If yes, please specify: _____

If yes, is the applicant receiving treatment for substance use? ☐ Yes ☐ No

Are you aware of any nursing or personal care needs for this patient? ☐ Yes ☐ No

Are there any other medical conditions? ☐ Yes ☐ No ☐ Needs Further Investigation ☐ Followed by specialists

If yes, please specify: _____

Does the applicant have a written Do Not Resuscitate (DNR) order? ☐ Yes ☐ No

Vaccination History: _____

_____

Basic Personal Issues:	Non-Issue	Issue
Eating/drinking	☐	☐
Dressing	☐	☐
Bathing	☐	☐
Continence	☐	☐
Grooming	☐	☐
Paresis/paralysis	☐	☐
Pain	☐	☐
Fatigue	☐	☐
Sleep disturbances	☐	☐

Cognitive Status:	Non-Issue	Issue
Orientation	☐	☐
Motivation/initiation	☐	☐
Judgement	☐	☐
Memory (short term)	☐	☐
Memory (long term)	☐	☐
Attention	☐	☐
Follow instructions	☐	☐
Insight	☐	☐
Perception	☐	☐

Mobility:	Non-Issue	Issue
Outdoor mobility	☐	☐
Falls/history of falls	☐	☐
Stamina	☐	☐
Balance/dizziness	☐	☐

Instrumental Needs:	Non-Issue	Issue
Meal preparation	☐	☐
Housekeeping	☐	☐
Shopping	☐	☐
Financial Management	☐	☐

Behaviour Issues:	Non-Issue	Issue
Ability to adjust to change	☐	☐
Impulse control	☐	☐
Mood disorder	☐	☐
Thought disorder	☐	☐
Wandering	☐	☐
Verbal aggression	☐	☐
Physical aggression	☐	☐
Sexually inappropriate	☐	☐
Self harm	☐	☐
Agitation	☐	☐
Easily angered	☐	☐
Frustration tolerance	☐	☐

Communication:	Non-Issue	Issue
Hearing	☐	☐
Vision	☐	☐
Language, comprehension	☐	☐
Language, expression	☐	☐
Pragmatics/conversational skills	☐	☐
Swallowing	☐	☐

Medical	Non-Issue	Issue
Seizures	☐	☐
Diabetes	☐	☐
Transfers	☐	☐
Weight	☐	☐

Additional functional information: _____

_____

Date completed: _____
(DD/MM/YYYY)

I, _____
First Name/ Last Name/ Profession/ Designation

Certify that the above information is complete and accurate to the best of my knowledge.

_____
Signature

Physician/Physician Assistant/Nurse Practitioner Contact information:

Address: _____

_____

_____

Telephone: _____

CPSO #/CAPA License #/ Registration #:

_____

Please return completed form to:

Head Injury Rehabilitation Ontario
Attn: Admissions Department
508 – 225 King William St.
Hamilton, ON L8R 1B1

Fax: 905 523-8211

A Promise of Hope After ABI