



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	Cognitive Status:	Non-Issue	Issue
Eating/drinking	<input type="checkbox"/>	<input type="checkbox"/>	Orientation	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	Motivation/initiation	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	Judgement	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>	Memory (short term)	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	Memory (long term)	<input type="checkbox"/>	<input type="checkbox"/>
Paresis/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Attention	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Follow instructions	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insight	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Perception	<input type="checkbox"/>	<input type="checkbox"/>

Mobility:	Non-Issue	Issue
Outdoor mobility	<input type="checkbox"/>	<input type="checkbox"/>
Falls/history of falls	<input type="checkbox"/>	<input type="checkbox"/>
Stamina	<input type="checkbox"/>	<input type="checkbox"/>
Balance/dizziness	<input type="checkbox"/>	<input type="checkbox"/>

Instrumental Needs:	Non-Issue	Issue
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>
Financial Management	<input type="checkbox"/>	<input type="checkbox"/>

Behaviour Issues:	Non-Issue	Issue
Ability to adjust to change	<input type="checkbox"/>	<input type="checkbox"/>
Impulse control	<input type="checkbox"/>	<input type="checkbox"/>
Mood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Thought disorder	<input type="checkbox"/>	<input type="checkbox"/>
Wandering	<input type="checkbox"/>	<input type="checkbox"/>
Verbal aggression	<input type="checkbox"/>	<input type="checkbox"/>
Physical aggression	<input type="checkbox"/>	<input type="checkbox"/>
Sexually inappropriate	<input type="checkbox"/>	<input type="checkbox"/>
Self harm	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>
Easily angered	<input type="checkbox"/>	<input type="checkbox"/>
Frustration tolerance	<input type="checkbox"/>	<input type="checkbox"/>

Communication:	Non-Issue	Issue
Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Language, comprehension	<input type="checkbox"/>	<input type="checkbox"/>
Language, expression	<input type="checkbox"/>	<input type="checkbox"/>
Pragmatics/conversational skills	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>

Medical	Non-Issue	Issue
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>
Weight	<input type="checkbox"/>	<input type="checkbox"/>

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