



APPLICATION FOR SERVICE

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

Veillez communiquer avec nous pour obtenir la version française de la demande de services.

TO BE COMPLETED BY APPLICANT / REFERRAL SOURCE

Type of service requesting: Residential Community Virtual Services

Personal Information

Applicant's Name: _____ Male Female Other
(first name) (last name)

Health Card Number: _____ / _____ Expiry Date: _____
version code DD/MM/YYYY

Date of Birth: _____ Date of Application: _____
DD/MM/YYYY DD/MM/YYYY

Address: _____
Number Street City Postal Code Apartment(Intercom #)

Home Telephone: _____ Cell Phone: _____

Email Address: _____

Marital Status: Single Married/Common Law Separated/Divorced Other: _____

Primary Language: English French Other: _____ Interpreter Required: Yes No

Decision Maker: Self Power of Attorney (POA)
 POA Personal Care: Name _____ Telephone: _____
 POA Property: Name _____ Telephone: _____

Current Living Situation: Alone With Relatives With Non-relative(s)

Accommodations:

House Apartment Supported Housing Residential Care Facility Hospital Long Term Care Facility Other

Is your rent geared to income? Yes: _____ No

Brain Injury Information

Date of Brain Injury: _____ Cause of Injury: _____
DD/MM/YYYY (anoxia, assault, motor vehicle accident, fall etc.)

Additional Comments: _____

Referral Information

Who is making the referral? Myself (if self, move to next section) Family Member Friend
 Community Service Provider Case Manager Lawyer

Name: _____ Position/Relationship: _____

Telephone: _____ Fax: _____ Email: _____

Relevant Treatment History (including current services)

Program/Facility/Hospital or Agency	Contact Information (name, position, phone number, email, fax)	Dates Involved

Medical Information / Mobility & Ambulation

Administering Medication(s): Self With help from others No medication prescribed

Able to walk up/down stairs: Yes No With assistance

Wheelchair: Does not use a wheelchair Manual Electric If yes, self-propel for nine meters or more: Yes No

Using Walker: Yes No Using Cane: Yes No

Supervision/Assistance with Walking: Yes _____ No
Please describe

Assistive Devices/Medical Equipment: Yes _____ No
Please describe

Smoking: Yes No If yes: With Assistance Without Assistance If yes, how many cigarettes per day: _____

Cannabis Use: Prescribed Non-Prescribed Used for: Recreation Anxiety Pain Other: _____

Fully vaccinated with COVID vaccine: Yes No Do not wish to disclose

Able to walk out nine meters and light a cigarette: Yes No With Assistance

Able to spend more than 30 minutes without supervision: Yes No

Additional Information

Highest Education Achievement: Grade School: _____ Grade High School: _____ Grade

College: _____ Diploma University: _____ Degree Trade: _____ Specialty

Current Employment: _____

Current Volunteer Position: _____

Current Recreational/Social Activities/Community Involvement: _____

Financial Information

Please Specify Source(s) of Income:

- | | | |
|--|--|--|
| <input type="checkbox"/> Ontario Disability Support Program (ODSP) | <input type="checkbox"/> Ontario Works (OW) | <input type="checkbox"/> Canada Pension Plan (CPP) |
| <input type="checkbox"/> Old Age Security (OAS) | <input type="checkbox"/> Veterans Affairs Canada | <input type="checkbox"/> Employment Insurance (EI) |
| <input type="checkbox"/> Long Term Disability (Private) | <input type="checkbox"/> Full Time Employment | <input type="checkbox"/> Part Time Employment |
| <input type="checkbox"/> Workplace Safety Insurance Board (WSIB) | <input type="checkbox"/> Settlement | <input type="checkbox"/> Insurance Claim |

Policy Information:

Name of Policy Holder: _____

Policy #: _____ Fax #: _____

Insurance Company: _____

Address: _____
Number Street Suite/Unit City Postal Code

Ongoing Litigation or Ongoing Claim Information:

Lawyer's Office: _____

Lawyer: _____ Phone #: _____

Insurance Company: _____

Adjuster: _____ Phone #: _____

Claim Number: _____

Rehabilitation Company: _____

Case Manager: _____ Phone #: _____

Nurse Consultant: _____ Phone #: _____

WSIB Policy Number: _____

Personal Support Network

Alternate Contact Name: _____
(first name) (last name)

Relationship: _____

Address: _____
Number Street City Postal Code Apartment(Intercom #)

Home Telephone: _____ Cell Phone: _____

Email Address: _____

Please list any other brain injury rehabilitation programs you have applied to:

Please attach copies of the following legal documents and relevant assessments and reports:

Power of Attorney for Property
Neuropsychology
Physiotherapy
Psychiatry

Power of Attorney for Care
Speech Therapy
Social Work
Current Medication

Neurology
Occupational Therapy
Psychology
Any other relevant treatment reports

I, _____
Name of Applicant or Decision Maker

Certify that the above information is correct, to the best of my knowledge.

Signature of Applicant or Decision Maker

Date (DD/MM/YYYY)

Consent to disclose personal and medical information to Head Injury Rehabilitation Ontario

Signature of Applicant or Decision Maker

Date (DD/MM/YYYY)

Please return completed applications and relevant assessments/reports 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