Head Injury Rehabilitation Ontario

APPLICATION FOR SERVICE

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

Veuillez 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: ☐ Yes ☐ No If yes, Cannabis Use: ☐ Prescribed ☐ Non-Prescribed

If Yes, 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:

- ☐ Ontario Disability Support Program (ODSP)
- ☐ Ontario Works (OW)
- ☐ Canada Pension Plan (CPP)
- ☐ Old Age Security (OAS)
- ☐ Veterans Affairs Canada
- ☐ Employment Insurance (EI)
- ☐ Long Term Disability (Private)
- ☐ Full Time Employment
- ☐ Part Time Employment
- ☐ Workplace Safety Insurance Board (WSIB)
- ☐ Settlement
- ☐ 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	Power of Attorney for Care	Neurology
Neuropsychology	Speech Therapy	Occupational Therapy
Physiotherapy	Social Work	Psychology
Psychiatry	Current Medication	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