

**APPLICATION FOR SERVICE
OUTREACH SERVICES**Email: admissions@hiro.ca Fax: 905-523-8211
Web: www.hiro.ca**TO BE COMPLETED BY APPLICANT / REFERRAL SOURCE***Veillez communiquer avec nous pour obtenir la
version française de la demande de services.***ELIGIBILITY CRITERIA**Please review the following criteria for HIRO's **Outreach Services**.**The applicant must:**

- have a diagnosis of an acquired brain injury, as confirmed by a physician;
- be eighteen years of age or older;
- not be diagnosed with a developmental disability, in-utero/at birth ABI, or pediatric (<16) ABI;
- demonstrate capacity for functional rehabilitation;
- be insured under OHIP;
- be located in the Hamilton, Burlington, Brant, Haldimand and Norfolk regions
- be medically and psychiatrically stable such that it will not interfere with participation in rehabilitation
- not have active substance use challenges that would influence participation in rehabilitation regularly;
- be independently responsible for managing personal care needs (i.e. independent in personal care or receives professional services/social support to complete custodial care needs);
- be oriented to person and place (may not be oriented to time, or to their exact location – e.g. “I’m at home” vs. the city or address);
- have basic self-awareness (e.g. able to notice if incontinent, to select appropriate clothes for the weather, etc.);
- respond to compensatory strategies and/or demonstrates some retention of new learning;
- be able and willing to tolerate structured rehabilitation programming 1+ hour(s) per session.

*If the applicant meets the eligibility criteria listed above,
please proceed to the next page to complete the application.*

PERSONAL INFORMATION

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

Health Card Number: _____ / _____ Expiry Date: _____
Applicant must have a valid physical copy of their health card version code DD/MM/YYYY

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

Current Living Situation:

House/Apartment Supported Housing Residential Care Facility Hospital Long Term Care Facility Unsheltered
 Other: _____

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 (Property): Name _____ Telephone: _____

Designation: Self Substitute Decision Maker Power of Attorney Public Guardian & Trustee Statutory Guardian
**Power of Attorney, Public Guardian & Trustee, Statutory Guardian and/or capacity assessments or documents must be attached.*

Decision Maker (Personal Care): Name _____ Telephone: _____

Designation: Self Substitute Decision Maker Power of Attorney Public Guardian & Trustee Statutory Guardian
**Power of Attorney, Public Guardian & Trustee, Statutory Guardian and/or capacity assessments or documents must be attached.*

BRAIN INJURY INFORMATION

Date of Brain Injury: _____
DD/MM/YYYY

Cause of Injury: _____
(anoxia, assault, motor vehicle accident, fall etc.)

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 / EMERGENCY CONSIDERATIONS

List any/all medical or emergency considerations HIRO staff should be aware of (e.g. allergies, seizures, panic attacks, behaviours, etc.):

REHABILITATION GOALS

Please check off any or all potential goals:

- | | |
|--|--|
| <input type="checkbox"/> Meal preparation and/or cooking | <input type="checkbox"/> Sleep Hygiene |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Social skills and friendships |
| <input type="checkbox"/> Cleaning and laundry | <input type="checkbox"/> Volunteering |
| <input type="checkbox"/> Managing appointments and health concerns | <input type="checkbox"/> Schooling |
| <input type="checkbox"/> Building a routine | <input type="checkbox"/> Learning more about my brain injury |
| <input type="checkbox"/> Driving or bus utilization | <input type="checkbox"/> Working |
| <input type="checkbox"/> Home maintenance and/or gardening | <input type="checkbox"/> Childcare tasks |
| <input type="checkbox"/> Passive Leisure (e.g. reading, crafts) | <input type="checkbox"/> Sobriety and/or addictions |
| <input type="checkbox"/> Active Leisure (e.g. sports, renovations, going to the gym) | <input type="checkbox"/> Emotional and mood support |
| <input type="checkbox"/> Finance Management | |
| <input type="checkbox"/> Other: | |

COMMUNICATION CONSIDERATIONS

If you have alternative communication needs, please select from the below (checkbox):

- Enlarged font
- Loud/clear audio
- Picture-based system (e.g. PECS)
- Text to audio
- None
- Other: _____

Please identify your preferred method of communication:

- Text
- Email
- Phone call
- Video Conferencing - Zoom/Teams
- Other: _____

FINANCIAL INFORMATION

Please identify applicable private funding sources:

- Long Term Disability (Private)
- Motor Vehicle Insurance
- Workplace Safety Insurance Board (WSIB)
- Extended Health Benefits
- Settlement
- Other: _____

Please attach any third party or private insurer information, if applicable.

If involved in litigation, please attach relevant contact information (e.g. legal counsel, case management).

EMERGENCY CONTACT

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

Relationship: _____

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

Home Telephone: _____ Cell Phone: _____

Email Address: _____

ADDITIONAL INFORMATION

Please identify other services you have applied to:

ABI SERVICES:

- Connect Communities
- Hamilton Health Sciences (ABI Program)
- Hamilton Brain Injury Association (HBIA)
- Brain Injury Community Re-entry (BICR)
- Brain Injury Association Niagara (BIAN)
- OTHER: _____

Please ensure the following are attached, if applicable:

- Decision maker paperwork (*Power of Attorney, Statutory Guardianship, and/or Public Guardian & Trustee*)
- Relevant medical consultation reports (*e.g. Neuropsychology, Occupational Therapy, Psychiatry etc.*)
- Insurance or litigation paperwork/contact information

I, _____

Name of Applicant/Substitute Decision Maker/Power of Attorney

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

Signature of Applicant/Substitute Decision Maker/Power of Attorney

Date (DD/MM/YYYY)

As the applicant or authorized Decision Maker, I consent for Head Injury Rehabilitation Ontario (HIRO) to receive this applicant's personal health information. I permit HIRO to disclose this applicant's personal health information, for the purposes of ABI service consultation, with the following personnel:

- HIRO's internal contract providers (e.g. Family Physician, Psychiatrist, Occupational Therapist, Physiotherapist etc.)
- Current care and/or shelter providers (e.g. hospital team, treatment team, residence etc.)
- Other system partners that may provide counsel to HIRO on the applicant's care and /or shelter (e.g. ABI System Navigator, Office of the Public Guardian & Trustee, Home and Community Support Services etc.)

Signature of Applicant/Substitute Decision Maker/Power of Attorney

Date (DD/MM/YYYY)

Print Name

Personal health information will be protected by HIRO as per the Personal Health Information Protection Act (PHIPA). The applicant and/or their Decision Maker may withdraw consent at any time, by informing HIRO verbally or in writing.

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



MEDICAL STATUS FORM- COMMUNITY

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

APPLICANT INFORMATION:

_____ / ____ / _____ _____ _____
 First Name/Last Name Date of Birth (MM/DD/YYYY) Height (cm) Weight (lbs)

_____ _____ _____ _____ _____ _____
 Address Street City Postal Code Unit # Phone Number

Is the applicant's diagnosis an acquired brain injury? Yes No
*(If **NO**, this applicant is not eligible for HIRO's services; please discontinue this form)*

If yes, please specify the diagnosis: _____

Please list any other diagnostics relative to function (e.g. mood disorders, cardiovascular or respiratory disease, metabolic diseases, autoimmune diseases, sleep disorders, neurological or neuromuscular disorders):

CAPACITY FOR REHABILITATION:

Successful applicants to HIRO's Outreach and Group services must demonstrate some capacity for rehabilitation. Please identify this applicant's abilities in the following areas:

Orientation	<input type="checkbox"/> Yes - Oriented to person and place <input type="checkbox"/> No - Not oriented to person, place, or time <input type="checkbox"/> Uncertain
Comprehension	<input type="checkbox"/> Yes - follows 1 to 2 step commands <input type="checkbox"/> No - cannot follow 1 to 2 step commands <input type="checkbox"/> Uncertain
Memory Deficit	<input type="checkbox"/> Has working memory deficit (cannot retain basic / simple information >5 minutes) or cannot sustain attention more than 5 minutes <input type="checkbox"/> Has short term memory deficit <input type="checkbox"/> Has no significant memory deficit <input type="checkbox"/> Uncertain
New Learning	<input type="checkbox"/> Yes - Can respond to compensatory techniques and/or demonstrates retention of new learning <input type="checkbox"/> Potential to learn basic skills using repetition and/or compensatory strategies (e.g. timers, alarms, calendars) <input type="checkbox"/> Unable to demonstrate any new learning, even with compensatory strategies <input type="checkbox"/> Uncertain
Demonstrates some insight into referral for rehabilitation	<input type="checkbox"/> Has some insight into physical, cognitive, or behavioural deficits <input type="checkbox"/> Admits to physical deficits or restrictions (e.g. hemiparesis, weakness, mobility issues, not allowed to drive or work), but may not recognize cognitive/ behavioural deficits <input type="checkbox"/> Has no self-awareness or insight into any deficits <input type="checkbox"/> Uncertain
Goals for rehabilitation	<input type="checkbox"/> Has some realistic life skills goals (e.g. meal preparation, showering, dressing) <input type="checkbox"/> Has unrealistic/ambitious goals for recovery (e.g. expectation to regain full function after SCI or hemiparesis, independent living, return to work or driving) <input type="checkbox"/> Requires exploration for non-pharmaceutical or non-physical restraint options for managing behaviours to improve quality of life <input type="checkbox"/> No rehabilitation goals

Please list any/all medical or emergency considerations HIRO staff should be aware of while servicing this Applicant (e.g. allergies, falls, seizures, panic attacks, self-harm, behaviours, etc.):

ATTESTATION

- I, confirm this Applicant is not being queried for/diagnosed with a progressive or degenerative disease/disorder (e.g. dementia, malignant tumor/cancer etc.)
- I, confirm the Applicant is not diagnosed with an in-utero/at birth ABI, pediatric (<16) ABI, or developmental disability that severely impacted reaching developmental milestones in youth. *If the brain injury occurred under age 16, please consider a referral for Developmental Services Ontario.*
- I, confirm that this Applicant is medically cleared for the use of basic Crisis Intervention and Prevention techniques including physical holds, blocks, and escorts when necessary to safely manage imminent risk of harm.

Date completed: _____
(DD/MM/YYYY)

I, _____ **certify that the above information is complete**
PRINT First Name/ Last Name/ Profession/ Designation

and accurate to the best of my knowledge at the time of application.

Signature: _____

Physician/Nurse Practitioner Contact information:

Address: _____

Telephone: _____

CPSO #/ Registration #: _____

Personal health information will be protected by HIRO as per the Personal Health Information Protection Act (PHIPA).

What is your relationship to this applicant?

- Family Physician
- Walk-In Physician
- Specialist/Consultant
- Other: _____

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Hamilton, ON L8R 1B1

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