Head Injury Rehabilitation Ontario

APPLICATION FOR SERVICE
GROUP SERVICES

Email: admissions@hiro.ca **Fax:** 905-523-8211
Web: www.hiro.ca

TO BE COMPLETED BY **APPLICANT / REFERRAL SOURCE**

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

ELIGIBILITY CRITERIA

Please review the following criteria for HIRO's Group 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 progressive or degenerative disease/disorder;
- ☐ 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;
- ☐ not have active substance abuse issues or use non-prescribed marijuana;
- ☐ be medically and psychiatrically stable such that it will not interfere with participation in rehabilitation or group activities;
- ☐ not require 1:1 support for any personal care (e.g. toileting, dressing, feeding) or medical needs (e.g. medication administration, emergency support outside of a 911 call). The applicant is responsible for bringing this support person.
- ☐ not require 1:1 supervision (as provided by Group staff). Group programs vary in size with some social events resulting in a 15:1 participant to staff ratio. The applicant is responsible for bringing in a support person if a higher level of supervision is required.
- ☐ be oriented to person and place;
- ☐ be able and willing to tolerate structured rehabilitation programming 1+ hour(s) per session;
- ☐ be able and willing to tolerate a social group environment without significant socially inappropriate behaviours (e.g. verbal aggression towards others, physical aggression, environmental aggression, or sexual inappropriateness will not be tolerated);
- ☐ be able to communicate basic needs (communication strategies may be verbally, in writing, with alternative/augmentative communication systems, or a picture-based system).

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 while attending Group (e.g. allergies, seizures, panic attacks, behaviours, etc.):

Group staff will not provide personal care or medication administration during group services. If you require aid in these areas, please bring a support person with you.

REHABILITATION GOALS

Please check off any or all potential goals:

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

Successful applicants for Group services must be able and willing to tolerate a social group environment. HIRO aims to maintain a safe space for all participants. If the applicant struggles with significant socially inappropriate behaviours such as verbal or physical aggression towards others, environmental aggression (throws items even if they don't intend to hit anyone), or sexual inappropriateness, it will not be tolerated, and the client may be asked to leave.

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
- ☐ 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

Head Injury Rehabilitation Ontario

MEDICAL STATUS FORM- COMMUNITY

Email: admissions@hiro.ca **Fax:** 905-523-8211
Web: www.hiro.ca

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