Head Injury Rehabilitation Ontario

CONSULTATION WAIVER: *Case Coordination*

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

TO BE COMPLETED BY **A CLIENT/CARE PROVIDER**

PERSONAL INFORMATION

Date of Application: _____ (DD/MM/YYYY) Applicant Name: _____ (First name / Last Name)

Date of Birth: _____ (DD/MM/YYYY) Sex: ☐ Male ☐ Female ☐ Other

Health Card Number: _____/_____ (version code)

Primary Contact: Phone: _____ Email: _____

I would like help with *(check all that apply)*:

☐ Income ☐ Education/Literacy ☐ Employment ☐ Housing ☐ Social Relationships ☐ Food Security
☐ Legal ☐ Health Services ☐ Community ☐ Navigation/Transportation

Current Living Situation:

☐ House/Apartment ☐ Supported Housing ☐ Residential Care Facility ☐ Hospital ☐ Long Term Care Facility ☐ Unsheltered

☐ Other: _____

BRAIN INJURY INFORMATION

Known Brain Injury: ☐ Yes ☐ No Cause of Injury: _____
(anoxia, assault, motor vehicle accident, fall etc.)

HELPS Screener Completed: ☐ Yes ☐ No Additional Comments: _____

AUTHORIZATION, CONSENT, AND WAIVER

To be eligible for free consultation services from Head Injury Rehabilitation Ontario (HIRO), I confirm that the person seeking services:

☐ Has an Ontario health card (i.e. insured under OHIP),

☐ Has a diagnosed brain injury **OR** screened positive on the HELPS Screener *(if you are unsure, please contact us anyway and we will help).*

Personal health information will be protected by HIRO as per the Personal Health Information Protection Act (PHIPA), under a consultation model.

_____ SIGNATURE OF Client/POA/SDM

_____ DATE

_____ CONTACT - EMAIL

_____ CONTACT - PHONE

Internal Review *(FOR HIRO ONLY):* _____