



Head Injury
Rehabilitation
Ontario

CLINICAL CONSULTATION WAIVER

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

TO BE COMPLETED BY A REGULATED HEALTH CARE PROVIDER (RHCP)

PERSONAL INFORMATION

Date of Application: _____
DD/MM/YYYY

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

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

Date of Birth: _____
DD/MM/YYYY

Current Service/Site: ☐ Hospital ☐ Extendicare ☐ HCCSS ☐ Other: _____

Permanent Address: _____
Number Street City Postal Code

Home Telephone: _____ Cell Phone: _____

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: _____

BRAIN INJURY INFORMATION

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

Additional Comments: _____

AUTHORIZATION, CONSENT, AND WAIVER

To be eligible for public consultation services from Head Injury Rehabilitation Ontario (HIRO), I confirm this patient:

- ☐ Has a primary diagnosis of an acquired brain injury (as confirmed by a physician),
- ☐ Was 16 years of age or older at time of brain injury (*for persons under the age of 16 at time of brain injury, please contact Developmental Services Ontario*),
- ☐ Is insured under OHIP,
- ☐ Is not under acute psychiatric distress

In my opinion this patient is appropriate for consultation with HIRO due to:

- ☐ Barriers to discharge/community placement due use of physical restraints
- ☐ Barriers to discharge/community placement due to real or perceived ABI-related behaviours

I have communicated with _____, _____
NAME TITLE/RELATIONSHIP

who, in their legal authority, have provided consent to disclose patient health information (medical and personal information) for the purposes of ABI consultation, with:

- Head Injury Rehabilitation Ontario (HIRO),
- Home and community support services,
- Other partners involved in this patient's care and/or shelter, as it relates to the objectives outlined above.

This patient and/or their Power of Attorney (POA) or Substitute Decision Maker (SDM) may withdraw consent at any time by informing HIRO verbally or in writing.

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

I, _____ from _____
NAME, REGULATORY TITLE AGENCY

confirm all information has been completed to best of my knowledge at the time of application.

SIGNATURE OF RHCP

DATE

CONTACT - EMAIL

CONTACT - PHONE #

A Promise of Hope After ABI