Alberta Health Services

Calgary Brain Injury Program Referral

Foothills Medical Centre
1403 – 29 Street NW, Calgary, AB T2N 2T9
Tel: 403-944-8571 **Fax: 403-944-8578**

Affix patient label within this box

Patient Demographics and/or Affix Patient Label

Date of Referral *(yyyy-Mon-dd)*	**Personal Health Number**		**RHRN**	
Surname	**First Name**		**Middle Initial**	**Date of Birth** *(yyyy-Mon-dd)*
Address	**City/Town**	**Province**	**Postal Code**	**Telephone number**
Referral Source		**Referrer Telephone number**		**Referrer Fax number**
Family Physician ☐ Same as referral source		**MD Telephone number**		**MD Fax number**
Interpreter Required ☐ yes ☐ no If yes, language required _____		**Alternative contact** *(name, relationship and number)*		

Reason for Referral (* marks mandatory fields)

*__Diagnosis__	*__Date of Injury__ *(yyyy-Mon-dd)*

Head Imaging Findings (CT/MRI) ☐ abnormal findings ☐ normal ☐ unknown / none available

*__Cause of Injury__ *(check all that apply)*

☐ Motor Vehicle Collision ☐ Fall ☐ Assault ☐ Tumour (pathology _____) ☐ Aneurysm
☐ Work related ☐ Sports related ☐ Anoxia/Hypoxia ☐ Stroke *(with cognitive deficits)*
☐ Other _____

Co-morbid Conditions

☐ Mental health diagnosis _____ ☐ Learning disorder ☐ Seizures / Epilepsy
☐ Progressive cognitive decline *(ie. dementia)* ☐ Alcohol / drug use at time of injury ☐ Addictions *(drug or alcohol)*
☐ Other _____

***Functional Concerns** *(what are the concerns the person is experiencing related to the brain injury)*

***Functional Goals for Rehabilitation / Service** *(what is the reason for this referral and/or expectations for an outcome)*

Please provide the following information if available

Length of Hospital Stay	Is the patient medically stable? ☐ yes ☐ no
Loss of Consciousness ☐ yes ☐ no ☐ unknown Duration *(if known)* _____	Post Traumatic Amnesia: ☐ unknown Duration: ☐ <24h ☐ >1 day to <1 week ☐ >1 week
Initial Best Glasgow Coma Scale ☐ unknown ☐ 13–15 ☐ 9–12 ☐ 3–8	Previous Brain Injury ☐ yes ☐ no ☐ unknown If yes, details _____

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Current Functional Status

Mobility ☐ independent ☐ aids/assist:

Other programs ☐ community fitness facility ☐ Living Well Program ☐ Home Care ☐ Day Program
Details/other _____

Transportation ☐ independent driving ☐ dependent on others for driving ☐ Access Calgary
☐ independent transit ☐ dependent on others for transit ☐ Other _____

Psychosocial concerns ☐ yes ☐ no If yes, please describe:

Living situation ☐ home *(independent)* ☐ home *(with others)* ☐ personal care *(group)* home ☐ supportive living/LTC
Details/other _____

Decision Making ☐ legal guardian *(self)* ☐ Private guardian ☐ Public guardian
Name/contact of guardian _____

Informal Supports available ☐ yes ☐ none identified
If yes, supports include *(check all that apply)* ☐ spousal ☐ parental ☐ adult child(ren) ☐ adult sibling(s)
☐ Other *(friends/other family, etc)* _____

Current function for basic or instrumental activities of daily living (ADLs)
☐ independent ☐ some supervision required ☐ some assistance required ☐ 24h supervision/dependent
Details/other _____

Vocational status *(check all that apply)* ☐ no change from pre-injury status ☐ working full time ☐ working part time
☐ unemployed ☐ retired ☐ home maker ☐ full time student ☐ part time student
☐ on medical leave *(from work or school)* ☐ modified duties due to injury
Details/other _____

Income source *(check all that apply)* ☐ Own Income/Family ☐ EI ☐ AISH ☐ Alberta Works ☐ CPP/OAS ☐ CPP-D
☐ Employment Disability Income (currently receiving ☐ sick time ☐ short term disability ☐ long term disability)
Details/other _____

Funding source *(check all that apply)* ☐ Alberta Health Care ☐ Out of Province Health Care
☐ Motor Vehicle Insurance (Section B Benefits) ☐ Workers Compensation Board (WCB) ☐ Legal funding
Other _____

Requested Action

☐ **Concussion Self-Management Education Group**
Open to patients 2 weeks to 3 months post-concussion. Provides general information about concussion and reviews guidelines of self-management for recovery. **please note, this is NOT a physician appointment*

☐ **Brain Injury Rehabilitation Clinic (requires a physician referral)**
This is an appointment with a physical medicine and rehabilitation physician (physiatrist) for patients with sequelae of an acquired brain injury *(refer to AB Referral Directory for more information)*

☐ **Outpatient Rehabilitation***
☐ North CAR ☐ Central CAR ☐ South CAR ☐ Other _____
Community Accessible Rehabilitation (CAR) in Calgary provides outpatient rehabilitation services.
For assistance or questions in accessing out-of-Calgary rehabilitation services please contact our Program.
** please note, patients with concussion <3 months or >18 months will not be accepted to CAR.*
Disciplines requested ☐ OT ☐ PT ☐ SLP ☐ RecT ☐ SW **Referral must include rehab goals*

☐ **Post-hospital Discharge Telephone Check-In**
A telephone call check-in after discharge from the hospital

☐ **Association for the Rehabilitation of the Brain Injured (ARBI)**
Slow stream rehabilitation for persons with severe brain injury

*****Please provide the follow information if available*****

☐ Neuropsychology report ☐ Assessment notes/results ☐ Treatment summaries
☐ Relevant consult notes ☐ Discharge summaries ☐ CT/MRI or relevant imaging

Upcoming Appointments *(specialists/dates if known)*

Is the patient aware and agreeable to the referral? ☐ Yes ☐ No