ABI Community Referral Form

The following information **must be included** (as indicated) to avoid any delays in processing your referral:

- ❑ Patient's Address, Phone Number and E-mail
- ❑ Patient's Health Card Number
- ❑ Diagnosis
- ❑ Date of Injury/Event
- ❑ Primary reason for referral
- ❑ Referral Destination (***only publicly funded services/programs are listed***) †
- ❑ Physician's Signature and Physician's Billing Number (*only if requesting Clinic or Outpatient Rehab services*)
- ❑ ***IMPORTANT* the following medical and rehab documentation** is required:
  - ❐ Medical
  - ❐ Consult notes
  - ❐ Initial and most recent MRI Scans, CT Scans, and/or imaging reports related to the brain injury
  - ❐ Neuropsychological Assessment Report (*if completed*)
  - ❐ Psychiatric consult notes or mental health reports (*if completed*)

- ❑ Client has been informed that they are responsible for arranging their own transportation to and from the programs and services requested.
- ❑ Client consented to the submission of this referral.

FAX TO: 416-597-7021

CONCUSSION referrals:

Only the following publicly funded clinics listed below accept concussion referrals:

- Physiatry – Toronto Rehab, University Health Network (Only for referrals < 1 year post injury. Patients must have a family doctor. Concussion injuries post MVC* are not accepted.)
- Sunnybrook (Only for referrals < 3 months post injury, with positive findings on brain imaging. MVC and WSIB injuries are not accepted.)

If your patient **does not** meet criteria for the 2 clinics above, visit www.abinetwork.ca/for-professionals/concussions to access the following resources:

- Toronto Concussion Navigator – Search for a clinic in Toronto that provides specialized concussion care.
- ABI Resources in Toronto and the GTA - Listing of clinics/programs in the GTA with expertise in managing concussion symptoms

The Toronto ABI Network will contact you directly if additional information is required or to provide alternatives for services. Service providers will contact the patient directly to coordinate services if accepted.

† *If you have any questions, please contact us at 416-597-3057*
* *Motor Vehicle Collision (MVC)*

Sender's name: _____ Phone number: _____

Total number of pages: _____

Toronto abi Network

ABI *Community Referral Form*

FAX TO: (416) 597-7021

MUST include all relevant brain injury medical and consult reports
(For example: Initial and most recent imaging reports, emergency room records and/or hospital admission/discharge notes.)
The referral will be returned if the above is not included.

Email: _____

Name: _____ _____
Last name First name

Preferred name: _____

Pronouns: _____ *(e.g., She/Her, He/Him, They/Them)*

Sex assigned at birth:
☐ female ☐ male ☐ prefer not to answer

Gender identity: _____
☐ prefer not to answer

Health Card #: _____ **Expiry:** _____ **Version:** ___ *if any* **Date of Birth:** _____ / _____ / _____ *year month day*

Diagnosis: _____ ☐ Concussion/mTBI

Date of Injury/Event: _____ / _____ / _____ *year month day*

Was this injury/event work-related? ☐ yes

Nature/Type of Injury/Event: ☐ mvc ☐ mvc *(motorcycle)* ☐ mvc *(on bicycle)* ☐ mvc (*pedestrian)* ☐ fall ☐ assault ☐ sporting
☐ trauma-other *(specify)* _____ ☐ unknown
☐ non-trauma *(specify)* _____

Primary Reason for Referral /Goal(s): _____

Number of visits since most recent head injury: to Emergency Department _____ *Specify ED Site*:_____
to Family Doctor _____

Referral Destination: To review the criteria of each of the following programs, please click on the respective link.

CLINICS **Head Injury Clinic:**
- ❒ Toronto Rehab/UHN Physiatry Clinic (< 1 year post injury. Concussion injuries post MVC are not accepted.)
- ❒ Sunnybrook (< 3 months post injury, with positive findings on brain imaging. MVC and WSIB injuries are not accepted.)

Neuropsychiatry Consultation: ❒ Toronto Rehab/UHN (moderate to severe only)

Neuropsychology Assessment Clinic: ❒ (CHIRS) (> 1 year post injury, with positive brain imaging, within Toronto & Central regions)

OUTPATIENT REHAB
- ❒ Hennick Bridgepoint Hospital/Sinai Health (< 1 yr post injury; includes Physiatry consultation)
- ❒ Toronto Rehab/UHN (< 2 yrs post injury, require 2 services, must have evidence on CT/MRI; includes Physiatry consultation.)

COMMUNITY

CHIRS ❒ Adult Day Services ❒ Community Support Services ❒ Residential Services ❒ Substance Abuse and Brain Injury* (SUBI)
❒ Clinical Groups* ❒ Smoking Treatment for Ontario Patients (STOP) Program* ❒ Neuro Behavioural Intervention Program
*Must have reliable case management support. Note: For all CHIRS services - individual must be 60 years of age and under, moderate – severe injury only.

Cota ❒ ABI Case Management ❒ Adult Day Service ❒ ABI Crisis Case Management

Scarborough Centre for Healthy Community (SCHC) ❒ ABI Outreach Team (Scarborough only)

March of Dimes Canada (York Region) ❒ ABI Community Outreach ❒ Aphasia Day Program ❒ Peer Group
ABI Supportive Housing: ❒ Toronto or ❒ Newmarket

PACE ❒ Adult Day Services ❒ Supportive Housing

West Park Healthcare Centre/UHN ❒ Behavioural Outreach ❒ ABI Adult Day Program

York Simcoe Brain Injury Services (Mackenzie Health/MODC) ❒ Behavioural Consultant ❒ Case Manager ❒ Rehab Worker
❒ Adult Day Program

OTHER: For referrals to Holland Bloorview Kids Rehabilitation, please submit directly to the organization.

Home Address: _____

_____

City:_____ Postal Code: _____

Primary Tel Number: _____

Alternate Tel Number: _____

Email: _____

Languages spoken: _____

Interpreter required: ☐ yes ☐ no

Home Living Situation:
☐ alone ☐ with others *(specify)* _____
Accommodation: ☐ homeless ☐ at risk of homelessness
☐ house ☐ apartment building ☐ supportive housing
☐ board & care ☐ other _____

Alternate Contact Information:
Name: _____
Phone: _____
Email: _____
Relationship to Patient: SDM ☐ POA ☐ Spouse ☐
Other: _____

 Revised January 2026

Referring Physician: _____
(Most responsible physician only, do not include Medical Residents)

Address: _____

City:_____ Postal Code: _____

Tel: _____ Ext: _____

Fax:_____

Signature* _____

**Billing # ***_____

**** Required for Clinics and Outpatient Rehab services only***

Family Physician: _____

Address: _____

City:_____ Postal Code: _____

Tel: _____

Billing #: _____

Referral Source: Contact name/position: _____ Tel:_____

Organization: _____ Pager/E-mail: _____

Client is Currently: ☐ at home ☐ other (specify): _____

If client in hospital, please provide: **Date of Admission:**_____ **Planned Date of Discharge**:_____

MEDICAL INFORMATION

Previous & Relevant Medical History: _____

Previous history of ABI: ☐ yes ☐ no Describe**:** _____

Pre-Injury History of Substance Use: ☐ yes ☐ no ☐ history not available **Status on admission:** _____

Current Substance Use: ☐ yes ☐ no ☐ not known **Substance Use Treatment Recommended:** ☐ yes ☐ no

Nicotine Dependence: ☐ yes ☐ no **Smoking Cessation Program Recommended:** ☐ yes ☐ no

Previous psychiatric history: ☐ yes ☐ no Describe: _____

Current psychiatric status: _____

Allergies:

_____

Is individual on antibiotics? ☐ yes ☐ no If yes, why: _____

Does individual have: ☐ MRSA ☐ VRE ☐ TB ☐ C-Difficile ☐ Other:_____

Seizures: ☐ yes ☐ no Dates**:** _____ Describe: _____

SERVICE INFORMATION ☐ CONSULT NOTES ATTACHED

TREATMENT HISTORY INCLUDING CURRENT SERVICES

Program/Facility/Physician/Therapies	Dates Involved (year/month/day)	Contact Name and Number

TRANSPORTATION: (*Please note: For most programs there are no transportation resources available*)

Client will be travelling: ☐ Independently ☐ With Assistance

Wheel-Trans: ☐ yes ☐ no **Wheel-Trans #:** _____ **YRT Mobility Plus:** ☐ yes ☐ no

Has the Ministry of Transportation been informed of the injury? ☐ yes ☐ no By whom? _____

SOCIAL INFORMATION

FINANCIAL INFORMATION:

Source:

☐ WSIB ☐ CPP ☐ Auto Insurance ☐ Ontario Works ☐ ODSP ☐ EI ☐ OAS ☐ STD ☐ LTD

☐ Other _____

Status (*initiated, date submitted, approved***):** _____

Previous or Current Involvement with the Justice System? ☐ yes ☐ no Details: _____

FUNCTIONAL INFORMATION **This section MUST be completed**

Please select your patient's issues based on the options listed below.

BASIC PERSONAL CARE:	ISSUE	Comments or Other Issues:
Eating/drinking	☐	
Dressing	☐	
Bathing	☐	
Toileting *(including continence)*	☐	
Grooming	☐	Identified risk(s):
Paresis/paralysis	☐	
Medication management	☐	
Pain/headaches	☐	
Fatigue	☐	
Sleep disturbances	☐	

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
☐ MD

MOBILITY:	ISSUE	Comments or Other Issues:
Walking	☐	
Wheelchair	☐	
Transfers	☐	
Outdoor mobility	☐	Identified risk(s):
Falls/history of falls	☐	
Stamina	☐	
Balance/dizziness	☐	

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
☐ MD

INSTRUMENTAL NEEDS:	ISSUE	Comments or Other Issues:
Meal preparation	☐	
Housekeeping	☐	
Shopping	☐	Identified risk(s):
Financial management	☐	

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
☐ MD

BEHAVIOUR ISSUES:	ISSUE	Comments or Other Issues:
Ability to adjust to change	☐	
Impulse control	☐	
Mood disorder	☐	
Thought disorder	☐	
Wandering	☐	
Aggressiveness	☐	Identified risk(s):
Sexually inappropriate	☐	
Suicidal risk	☐	
Agitation	☐	
Easily Angered	☐	
Frustration Tolerance	☐	

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
☐ MD

COMMUNICATION:	ISSUE	Comments or Other Issues:
Hearing	☐	
Vision	☐	
Language, comprehension	☐	
Language, expression	☐	Identified risk(s):
Pragmatics/conversational skills	☐	
Swallowing	☐	*(specify diet, food texture)*

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
☐ MD

COGNITIVE STATUS:	ISSUE	Comments or Other Issues:
Orientation	☐	
Motivation/initiation	☐	
Judgement	☐	
Memory (short term)	☐	
Memory (long term)	☐	
Attention	☐	Identified risk(s):
Follow instructions	☐	
Insight	☐	
Perception	☐	

Completed by:
☐ OT ☐ Nurse
☐ PT ☐ Other
☐ SW ☐ SLP
☐ MD

This referral was completed by (*name*) _____ on (*date*) _____