

**ONTARIO COMMUNITY BASED  
NON-PROFIT SERVICE PROGRAMS FOR  
ADULTS WHO LIVE WITH  
THE EFFECTS OF BRAIN INJURY**

**REQUEST FOR SERVICE**

**Provided by:**

**VISTA CENTRE  
107-31 VAN LANG PRIVATE  
OTTAWA, ONTARIO  
K1Z 1A4  
(613) 798-8319**

**Instructions for Completing Request for Service:**

It is encouraged that the individual requesting service participate in the completion of this form as much as possible. This can be done in conjunction with either a service provider and/or significant other. Please print or type.

Forms that are incomplete may be returned and will delay the application process. We would appreciate a copy of any documentation that supports the request and assists in determining the needs. It is required that a neuropsychology and/or team report be submitted with the request.

# AUTHORIZATION FORM

I, \_\_\_\_\_, have completed or have had this Request for Service  
(Print Name)  
 completed for me. I give permission for the information contained herein to be shared with the agencies  
 listed below in order to facilitate appropriate and timely service provision.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Legal Guardian/Committee Signature  
 (if applicable)**

\_\_\_\_\_  
**Please Print Applicant Name**

\_\_\_\_\_  
**Please Print Guardian / Committee Name**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

**If an individual other than applicant completed this document, please sign below.**

\_\_\_\_\_  
**Completed by (please print)**

\_\_\_\_\_  
**Relationship to individual**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

<b>ONTARIO COMMUNITY BASED NON-PROFIT PROGRAMS FOR ADULTS WHO LIVE WITH THE EFFECTS OF BRAIN INJURY</b>			
<i>Program Name</i>	<i>Address</i>	<i>Phone Number</i>	<i>Fax Number</i>
Acquired Brain Injury Program – The Rehabilitation Centre	1800 Bank Street, Suite 315 Ottawa, ON K1V 0W3	(613) 731-1106	(613) 731-5813
Brain Injury Community Re-Entry (Niagara) Inc.	261 Martindale Rd., Units 12&13 St. Catharines, ON L2W 1A1	(905) 687-6788 1-800-996-8796	(905) 641-2785
Brain Injury Services of Hamilton	307 King Street East, Suite 303 Hamilton, ON L8N 1C1	(905) 523-8852	(905) 523-8211
Brain Injury Services of Northern Ontario	185 South Court Street, Suite 205 Thunder Bay, ON P7B 2X7	(807) 345-1188	(807) 345-1428
Brain Injury Services of Simcoe County (BISS)	64 Cedar Pointe Drive, Unit 1413 Barrie, ON L4N 5R7	(705) 734-2178	(705) 734-1598
Community Head Injury Resource Services of Toronto (CHIRS)	2150 Islington Avenue, Unit 203 Etobicoke, ON M9P 3V4	(416) 240-8000	(416) 240-1149
Dale Brain Injury Services Inc.	815 Shelborne Street London, ON N5Z 4Z4	(519) 668-0023	(519) 668-6783
Regional Community Brain Injury Services	303 Bagot St, LaSalleMews,Ste 401 Kingston, ON K7K 5W7	(613) 547-6969	(613) 547-6472
Peel Halton Acquired Brain Injury Services (PHABIS)	151 City Centre Drive, Suite 404 Mississauga, ON L5B 1M7	(905) 949-4411	(905) 949-4019
Vista Centre	31 Van Lang Private, Suite 107 Ottawa, ON K1Z 1A4	(613) 798-8319	(613) 798-9909

Date of Request:

**REQUEST FOR SERVICE**

The following can be completed by the individual, family and / or referring agent:

**Personal Information**

Client Name (Last Name, First Name)		Date of Birth (mm/dd/yy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address		Apt. #	Home Phone Number:
City	Prov.	Postal Code	Health Card Number:
Marital Status:		Primary Language:	
Citizenship: <input type="checkbox"/> Canadian <input type="checkbox"/> Landed Immigrant <input type="checkbox"/> Other		Do You Require Services in Languages Other than English? If so which?	
Do you wear a Medical-Alert bracelet or necklace? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a resident of Ontario? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, how long?</b>	

**Brain Injury Information**

Date of Injury:	Cause of Injury (e.g. anoxia, assault, motor vehicle accident, fall, etc.):
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**Personal Support Network /Emergency Contacts**

Name (Last Name, First Name)		Relationship	Contact Person <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		Home Phone Number	
City	Prov.	Postal Code	Work Phone Number
Name (Last Name, First Name)		Relationship	Contact Person <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		Home Phone Number	
City	Prov.	Postal Code	Work Phone Number

*(add additional pages if needed)***Referring Agent (who is making the request):**

Name (Last Name, First Name)		Relationship:	Contact Person <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		Work Phone Number	
City	Prov.	Postal Code	Fax Number:

**For office use only****DO NOT WRITE IN THIS SPACE**

SIRUS	Beh	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	Cog.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	Physical Status	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	Psychiatric Status	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	Prognosis	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	Medical Status	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	R.R.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	Medical/Psych. Req.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Education and Employment		
Name of Last School Attended:	Address of School:	
Level Attained:	Year Completed:	
Name of Last Employer:	Position:	How long were you there?

**Leisure:** What did you enjoy doing in your spare time before your injury?

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Reason for Referral
<b>Individual</b> (What would you like to achieve through participating in the program?):
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<b>Referring Agent</b> (to supplement the above):
<hr/> <hr/> <hr/> <hr/>

**Type of Service Requested:** (e.g. day program, residential)

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**Please describe current living situation** (e.g. share apartment with brother)

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**Have services from any other agencies been requested?** (e.g. Vocation Rehabilitation, Residential support)

No  Yes, please specify using name of agency, date and status of application: \_\_\_\_\_

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*(add additional pages if necessary)*

**Are you currently receiving any services?**  No  Yes, please include the agency, your contact's name, address and phone number: \_\_\_\_\_

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**Treatment History**

Name of Facility / Program	Contact Person	Address, phone number	Dates involved? (e.g. Aug 95)

**Medical Professionals:**  
(e.g. General Practitioner, Neuro-Psychologist, Neurologist, Psychiatrist, Physiatrist)

Name	Specialty	Address, Phone Number	Last Seen

**Medications:**

Name of Medication	Dosage	Reason	Date Prescribed	Side Effects

*(add additional pages if necessary)*

Medication Administration - Self  or  Other, specify who \_\_\_\_\_

**Seizures**

Have you ever experienced a seizure?  No  Yes, Date of last seizure: \_\_\_\_\_  
 Frequency of seizures:  Daily  Weekly  Monthly  Other, please specify \_\_\_\_\_

Type of seizure: \_\_\_\_\_

**History of Alcohol / Nonprescription Use:**

**Before your injury**, how often would you drink? Daily Weekly Monthly Never  
How much would you drink? \_\_\_\_\_

**Since your injury**, how often do you drink? Daily Weekly Monthly Never  
How much do you drink? \_\_\_\_\_

**Have you** experimented with non-prescription drugs? (marijuana, hashish, L.S.D., etc.) Yes No

**History of Psychiatric Support**

Have you ever experienced behavioural problems (mood / sleep disorders, hallucinations, etc) that have required psychiatric intervention? No Yes, please describe: \_\_\_\_\_

(add additional pages if needed)

Do you have difficulty *controlling yourself* in other ways, not yet been mentioned (anger, touching others, ....)? No Yes, please describe: \_\_\_\_\_

**Are you undergoing treatment for the above issues now (A.A., private counseling, etc.)?**  
No Yes, please describe: \_\_\_\_\_

Do you have a *criminal record*? No Yes, please describe: \_\_\_\_\_

(add additional pages if needed)

Is there a *court case* pending? No Yes, please describe: \_\_\_\_\_

**Physical Status**

Do you require a *wheelchair*? No Yes, is it - manual? motorized?

Do you require *other assistive devices*? No Yes, please state what is needed: \_\_\_\_\_

Do you require *attendant care*? No Yes **If yes**, please describe: \_\_\_\_\_

Do you require supervision or assistance with walking? No Yes **If yes**, does it apply to:  
level surfaces stairs or both

Can you transfer independently? Yes No, please describe assistance needed: \_\_\_\_\_

Are there any communication issues? No Yes, please describe: \_\_\_\_\_

Any other physical conditions that should be mentioned? (allergies, heart conditions, diet restrictions, etc) No Yes, please describe: \_\_\_\_\_

## Required Reports

Please arrange for a neuro-psychology and/or team reports be submitted with the application.

Photocopies will be accepted.

*Please indicate below which reports are available -*

Reports from:	Available	Not Available	Facility Name:
Neurosurgery			
Neuropsychology			
Speech Therapy			
Physiotherapy			
Occupational Therapy			
Social Work			
Psychology			
Discharge Summaries from Rehabilitation Medicine			
Other Programs			

### Financial Information

Are you receiving benefits from *No Fault Insurance*?  No  Yes, please describe benefits:

\_\_\_\_\_

Is there a Case Manager Involved?  No  Yes, please include company name, contact person, address and phone number:

\_\_\_\_\_

Do you have direct access to your income -  Yes  No, please include name, address and phone number of committee or guardian as well as attaching proof of committee or guardianship: \_\_\_\_\_

\_\_\_\_\_

**If applying for any subsidy, the below section must be completed by the applicant or the person responsible for financial matters.**

Please note that individual agencies may require further information.

When more information is needed, the agency will contact you about what is required.

### Financial Disclosure - Source of Income

Check appropriate source of income

*Social Assistance*

Family Benefits Allowance (F.B.A.)       General Welfare (G.W.A.)       Vocational Rehabilitation Services (V.R.S.)

*Long Term Disability*

Canadian Pension Plan (C.P.P.)     Worker's Compensation (W.C.B.)       Long Term Disability (private)

*Private Funding:*

Settlement                                       Structured Settlement                       Inheritance

*Employment:*

Part Time                                       Full Time

*Income Generating Assets* - please describe,

Amount of income per month? \_\_\_\_\_

I, \_\_\_\_\_ certify that the above mentioned financial information is correct, to the best of my knowledge.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date