CLIENT APPLICATION FORM

DATE OF APPLICATION: ……..

NAME OF CLIENT: ……

CURRENT PLACE OF RESIDENCE: ……

HOME ADDRESS: ……

CITY: ……. PROVINCE: ……POSTAL CODE: ……..

PHONE: (……) …….. …….. CELL: (……) …….. ……..

EMAIL: ……

REFERRAL SOURCE

( ) Calgary Brain Injury Program ( ) Carewest Dr. Vernon Center - 2 East

( ) Long Term Care Facility ( ) Halvar Jonson Centre for Brain Injury

( ) Community Accessible Rehabilitation – CAR ( ) Family ( ) Other: ……

REFERRING PERSON

RELATIONSHIP TO CLIENT: ……

PHONE: (……) …….. …….. EMAIL: ……

PERSONAL INFORMATION

PERSONAL HEALTHCARE #: ……

ACCESS CALGARY REGISTRATION #: ……

DATE OF BIRTH: ……

FUNDING SOURCE: ( ) Alberta Health Services ( ) Motor Vehicle Accident Insurance

( ) Other insurance (DVA, Treaty, WCB) ( ) No Insurance

GUARDIANSHIP

( ) Legal guardian (self) ( ) Private guardian (name and contact) ( ) Public guardian (name and contact)

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GOALS OF CARE: ☐R1 ☐R2 ☐ R3 ☐M1 ☐ M2 ☐C1 ☐ C2

MEDICAL HISTORY

DATE OF INJURY OR ONSET: ……

LENGTH OF TIME IN COMA: …… GLASGOW COMA SCALE (INITIAL): ……

PRIMARY DIAGNOSIS: ( ) Traumatic Brain Injury ( ) Acquired Brain Injury (Stroke, Aneurysm, Infection, etc)

( ) Anoxia ( ) Other: ……

OTHER MEDICAL CONDITIONS:

	Alcoholism/ Substance abuse		Glaucoma / Cataracts
	Allergies:		Heart Disease
	Arthritis		High Blood Pressure
	Asthma / COPD		Hypo/Hyper thyroid
	Auto Immune		Mental illness:
	Cancer		Obesity
	Depression/ Anxiety		Osteoporosis
	Diabetes		Seizures
	Chronic Infectious disease (HIV, MRSA, Hepatitis)		Surgeries:

OTHER: ……

IS THIS CLIENT MEDICALLY STABLE? ……

THERAPIES PREVIOUSLY RECEIVED (Including specialist visits and rehabilitation):

……

……

THERAPIES PRESENTLY RECEIVED:

……

……

TOLERANCE FOR ACTIVE REHABILITATION PER DAY:

( ) 1 HOUR ( ) 2 HOURS ( ) 3 HOURS ( ) OVER 3 HOURS

HAS THIS REFERRAL BEEN DISCUSSED WITH CALGARY BRAIN INJURY PROGRAM? ( ) Yes ( ) No

FAMILY PHYSICIAN**:** ……

FAMILY PHYSICIAN PHONE NUMBER: (……) …… ……

HAS CLIENT SEEN A NEUROLOGIST OR PHYSIATRIST? PLEASE NAME: ……

……

SOCIAL HISTORY

EDUCATION: ..... MARITAL STATUS: .....

SUPPORTIVE FAMILY MEMBERS: .....

OTHER SUPPORTS: .....

IS THERE ANY OTHER RELEVANT INFORMATION WE SHOULD KNOW ABOUT? .....

.....

CURRENT STATUS

SWALLOWING; CONCERNS AND DIET: .....

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APHASIC: ( ) Yes ( ) No

SHOWS EMOTIONS? FOR EXAMPLE; ANGER, SADNESS, HAPPINESS: ( ) Yes ( ) No

MOBILITY AIDS USED (e.g. CANES, BRACES, WHEELCHAIRS) .....

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COMMENTS: .....

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IS CLIENT AWARE AND AGREEABLE TO THIS REFERRAL? ( ) Yes ( ) No

PRESENTLY I, (Client) PARTICIPATE ……TIMES/WEEK IN THE COMMUNITY

(PLEASE CONSIDER THE NUMBER OF TIMES YOU ARE GETTING OUT OF YOUR PLACE OF RESIDENCE
e.g. GOING SHOPPING, VISITING A FRIEND, ATTENDING CHURCH OR COMMUNITY GROUP ACTIVITY etc.)

PLEASE PROVIDE EXAMPLES OF YOUR COMMUNITY OUTINGS: .....

ADDITIONAL COMMENTS: .....

.....

.....

APPLICATION COMPLETED BY: .....
(PLEASE PRINT NAME)

SIGNATURE: ..... DATE: .....

arbi making life better
Association for the Rehabilitation of the Brain Injured

CONSENT FOR RELEASE OF CLIENT INFORMATION WITH CARE PROVIDERS

I, _____, am hereby in agreement with ARBI
(Client/guardian name)
sharing client information with care providers for _____
(Client name)
related to the client's health and wellbeing.

_____ _____
Signature of Client/guardian Date

_____ _____
Signature of witness Date

This consent remains valid for 3 years

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CONSENT FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

1. In situations other than those specifically excluded in Section 24 of the Alberta Hospitals Act, this form must be signed by the patient/guardian/or other legally authorized party prior to releasing and/or obtaining information about him/her.

2. When requesting information, this form must be accompanied by a covering letter which indicates what information is requested.

RE: _____
(Print client's name)

I, _____, hereby authorize Association
(Print client/guardian's name)

for the Rehabilitation of the Brain Injured (ARBI) to:

1. Obtain health information and/or medical records from hospitals, rehabilitation centers, care centers, physicians or other health care personnel and other service providers, subject to the following exclusions, if any, _____

2. Release health information and/or medical records to referring hospitals, rehabilitation centers, care centers, physicians, other health care personnel and/or service providers, subject to the following exclusions, if any _____

3. To provide or use a photocopy/fax copy of this release.

_____ _____
Signature client/guardian Date

_____ _____
Signature of witness Date

This consent remains valid for 3 years