Skills Society, ABI Program
Suite 203, 124 Street Business Park East
10408 – 124 Street
Edmonton, AB, Canada
T5N 1R5 PH:780-496-9686 ext.242

Date:

Acquired Brain Injury Program Supports for Community Living Service Referral Form

*Please note; if you are eligible for PDD Funding then you are not eligible for this program.

Client Information

First Name:	Last Name:	Date of Birth:
Home Phone #:	Cell Phone #	
Special considerations when contacting you (aphasia or other communication difficulties, best person to contact, etc.):		
Address (please note if this is a group home or facility):	City:	Postal Code:
Health Care Number #:	Email Address:	
Emergency Contact Person:	Relationship:	Phone #:

Referral Information

Referral Completed by:	Phone #
Organization:	Fax #:

Brain Injury Information & History

Date of Injury:	Cause of Injury**:**	Type of Injury (Stroke, tumor, etc.):
Hospital Admission (and dates if known): Severity of Injury:		
Co-occurring diagnosis: ◯ Active addictions ◯ Physical disability ◯ Mental health concerns *(Check all that apply)* ◯ Recovering addictions ◯ Psychiatric disorder ◯ Other (Serious medical concerns, etc.)		
Please elaborate on any boxes checked above:		

Programs attended to support above diagnosis:

Reason for Referral (Problem soving, Medical Health practices, Personal support network, Community Participation, Daily living skills)

Please fill in the following programs and supports that have been attended since brain injury:

Program:	**Facility/Company and Description:**	**Dates (if known):**
Physical, Occupational or Recreational Rehabilitation		
Homecare		
Brain Injury Supports (Brain Care Centre, Networks, etc.)		

Cautions (History of aggression/self harm/substance abuse/ communicable diseases, Criminal record, suicide, bed bugs) *Please provide supporting documentation

Who are your natural supports and what do they help you with?

Name: Phone #

Does your natural support want to be present at the Intake Meeting?

What is your current living situation, i.e. living alone or with others?

How many hours/week do you foresee needing services?

Practitioner	**Name**	**Company/Facility**	**Phone Number**
Family Doctor			
Medical Practitioner/Specialist			

Social Worker			
Other			

Program Use only	
Date referral received:	Date of contact:
Skills Program Staff:	Intake Date:

Supporting Documentation including hospital discharge summaries (proof of brain injury) and neurophysiological documentation must be included with this form or your application may be delayed or denied. If you need help acquiring the necessary documentation, please contact our office (see below).

All referral forms must be completed to the best of your abilities or it could be sent back to writer. All referral forms and supporting documentation are confidential.

Mail, Email or Fax Referral Form and Supporting Documents to:

Skills Society for Community Living Services
Suite 203, 124 Street Business Park East
10408 – 124 Street
Edmonton, AB, Canada

Phone: (780) 977-6073
Fax: (780) 482-6395
michelles@skillssociety.ca

Acquired Brain Injury
Program Coordinator
Michelle Schwengler