Acquired Brain Injury Services
201 - 9440 202 Street
Langley, BC V1M 4A6
Office : 604-514-7430
Fax : 604-528-5454

Inpatient Referral Form

A. DEMOGRAPHIC

Last Name	First Name	Preferred Name
DOB (DD-MM-YY)	Personal Health Care Number	Gender ☐ Man ☐ Woman ☐ Other(please specify):
Address	City, Province, Postal Code	Email Address
Home Telephone	Cell	Marital Status (if applying for Community bed)
Primary Language	Secondary Language	Do you self-identify as Aboriginal/Indigenous? If so, ☐ First Nation ☐ Mètis ☐ Status ☐ Inuit ☐ Non-Status ☐ Other(specify):

Immigration Status
☐ Landed Immigrant ☐ Canadian Citizen ☐ Refugee Status
☐ VISA Permit ☐ Sponsored Immigrant ☐ Other _____

Second Contact	Relationship	Telephone
Third Contact	Relationship	Telephone

B. REFERRAL SOURCE

Referring Person	Relationship	Telephone	Email
Family Physician	Telephone	Fax Number	

***** If the referral is from Outpatient Rehab Services - please include End of Program Form along with this referral *****

C. BRAIN INJURY INFORMATION

Date of Injury: _____

Type of Brain Injury:

☐ Aneurysm ☐ Anoxia/Hypoxia ☐ Arteriovenous Malformation
☐ Hemorrhage ☐ Traumatic Brain Injury ☐ Tumour
☐ Infection ☐ Stroke - Ischemic ☐ Stroke - Hemorrhagic
☐ Other _____

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D. EVIDENCE OF BRAIN INJURY (If reports are not available through Meditech - Please fax to 604-528-5454)

Choose one:

- ☐ CT Scan Date:_____
- ☐ Physiatry Report Date:_____
- ☐ Other Report Date: _____
- ☐ MRI Date: _____
- ☐ Neurology Report Date: _____

E. OTHER PROGRAMS THE CLIENT HAS BEEN INVOLVED WITH – PAST AND PRESENT

- ☐ ABI Services
- ☐ First Nation's Health Services
- ☐ CLBC
- ☐ Mental Health Services
- ☐ Home Health Services
- ☐ Substance Use Services
- ☐ Outpatient Rehab Services
- ☐ Familiar Faces Program
- ☐ Inpatient Rehab

Is this injury the result of any of the following?

- ☐ Motor Vehicle Accident
- ☐ Work Related Accident
- ☐ Victim of Crime

F. CLIENT FACTORS

- ☐ Mental health concerns
- ☐ Currently requires supervision at all times
- ☐ Personal care needs
- ☐ Complex medical issues - ongoing
- ☐ Criminal history and/or on probation
- ☐ Behavioural concerns
- ☐ History of unstable housing
- ☐ Cognitive impairment (moderate-severe)
- ☐ Frequent ER admissions
- ☐ Concerns of Abuse/Neglect/Self Neglect
- ☐ Active or recent history of substance use
- ☐ Other _____

Additional Information - (i.e. support systems; other concerns):

_____

_____

G. REASON FOR REFERRAL (Please note that if patient requires rehab services -please refer to FH Outpatient Services).

Client is anticipated to be discharged home and needing Community Support Services: ☐ Yes ☐ No

Client is anticipated to require an ABIS Community bed resource: ☐ Yes ☐ No

Is client/ family aware of this Referral? ☐ Yes ☐ No

Estimated discharge date : _____

Please fax completed form to 604-528-5454