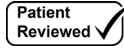




Request for Acquired Brain Injury Services



Acquired Brain Injury Services: 201-9440 202 Street, Langley, BC V1M 4A6 Intake: 604-514-7460 Fax: 604-528-5454

Please send completed referral form via mail or fax.

| A. Your Information | | |
|---|---|---------------------|
| Last Name: | First Name: | Preferred Name: |
| Date of Birth (dd/mm/yy): | Personal Health Number: | Preferred Language: |
| Pronouns: <input type="checkbox"/> He/His/Him <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other, please specify: _____ | | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Identify As: _____ | | |
| Address (City, Province, Postal Code): | | |
| Main Phone Number: | Alternative Phone Number: | Email: |
| Other Person to Contact: | Relationship: | Phone Number: |
| Primary Health Care Provider Name: | Professional Title: | Phone Number: |
| Do you wish to identify as an Aboriginal / Indigenous person? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer | | |
| If yes , select ALL that apply: | | |
| <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Status Non-Status <input type="checkbox"/> Other, please specify: _____ | | |
| Citizenship Status: | | |
| <input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Landed Immigrant <input type="checkbox"/> Sponsored Immigrant <input type="checkbox"/> Refugee Status <input type="checkbox"/> VISA Permit | | |
| <input type="checkbox"/> Other, please specify _____ | | |
| B. Who helped you with this referral? | | |
| <input type="checkbox"/> No one <input type="checkbox"/> Family or Friends <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Other, please specify: _____ | | |
| Referring Person Name: | Relationship: | Phone Number: |
| C. About your brain injury | | |
| Date of Injury: | Which hospital or clinic did you attend, if any? | |
| Is this injury from: | | |
| <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Work-Related Injury <input type="checkbox"/> Victim of Crime <input type="checkbox"/> Other, please specify: _____ | | |
| Type of Brain Injury: | | |
| <input type="checkbox"/> Anoxia or Hypoxia (lack of oxygen) | <input type="checkbox"/> Traumatic Brain Injury (bump, hit or jolt to the head) | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tumour (Abnormal growth) | |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Other /Unknown _____ | |
| Version: B | | |
| Date: January 15, 2024 ©2024 Fraser Health Authority (FHA). FHA authorizes use/reproduction/modification of this publication for non-commercial healthcare or educational purposes only | | |



Request for Acquired Brain Injury Services Cont'd

D. About you**Current living environment:**

Alone With family With friends Other _____

I am having trouble with the following daily activities:

- Getting dressed Showering Using the toilet Completing household duties Focussing Sleeping
- Managing money Paying Bills Shopping Getting around the community Watching television
- Other, please specify:

How long have you had these difficulties with these activities?

I have the following types of support:

Is there anything else you would like us to know?

Client Signature:**Date the form was completed:**

Any questions please contact our Intake line at 604-514-7460