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Acquired Brain Injury Services Application Package

Submit Completed Application to: _____

By Mail: Acquired Brain Injury Program
#200 - 218 Blue Mountain St.,
Coquitlam, BC V3K 4H2

Or By Fax: (604) 936-0955

General Eligibility Criteria

The Ministry of Health has adopted the World Health Organization definition of Acquired Brain Injury: Damage to the brain, which occurs after birth and is not related to a congenital or a degenerative disease. These impairments may be temporary or permanent and cause partial or functional disability or psychosocial maladjustment (Geneva 1996) Based on this definition, to be eligible for service an Applicant must have experienced a discreet event that caused brain damage. This would include traumatic injuries such as falls or assaults and organic injuries such as strokes or aneurysms. It does not include degenerative or progressive diseases (e.g. Multiple Sclerosis, Huntington's) or congenital disorders (e.g. Down's Syndrome)

In order to qualify for admission to Acquired Brain Injury Services (ABIS), all clients must also meet the following eligibility requirements:

1. Medical evidence of an acquired brain injury (e.g. CT scan, MRI, Neurological / Physiatry report)
2. Clients should be aged 19 and over.
3. Meet citizenship and residency requirements as defined in FH Policy;
4. Evidence of financial need: i.e. have no (or limited) funding or access to services from other sources
5. Live within geographic boundaries of Fraser Health;
6. Complete and submit all Acquired Brain Injury Program application forms and required documents/reports;
7. Potential to benefit from services (as determined by ABIS).

In addition to the above general criteria, certain programs within the ABIS have additional eligibility requirements.

Applications will not be processed unless all requested information and documentation is included.
Please be sure to include the following documents:

- ☐ Referral Form
- ☐ Application Appendices (if required) *A: Neuro Behavioral Inventory* *B:Legal History Form*
  Consent Form
- ☐ Proof of ABI : CT Scan, Neurologist Report, Physiatrist Report, or MRI Report
- ☐ Medical/Rehabilitation or Hospital discharge reports
- ☐ Proof of current income (if applying for Residential Services)

If you need help with this application, please contact the Program at: (604) 520-4175

Due to limited program capacity, the ABIS does not provide hospital discharge assessments for home safety – please consult Applicant's local Home Health office. Fraser Health Central Home Health Line: 1-855-412-2121

If you question whether the Applicant is eligible for service, before taking the time to complete this application clarify this question by contacting the ABIS - (604) 520-4175.

All services are subject to waitlist prioritization and availability of funding.

Revised Aug 2017

FRASER HEALTH ACQUIRED BRAIN INJURY SERVICES (ABIS) REFERRAL FORM

Client Name _____ (last name, first name, initial) Date of Injury _____ (d/m/yr) Date of Birth _____ (d/m/yr)

Client's Current Location	Hospital ○ Community ○

Is Client at Imminent Risk without ABIS Services?	No ○ *Yes ○

*If client is at risk without services - please explain their situation here, including safety concerns:

Discharge Date from Hospital _____ (d/m/yr) Most Responsible Physician _____ (last name, first name)

Which Hospital: _____

Requested ABI Services - Please Identify all of the Client's Needs

Rehabilitation Services No ○ Yes ○

- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Speech Language Therapy
- ☐ Counselling

Community Support No ○ Yes ○

- ☐ Day Program
- ☐ Community Support Worker

ABIS Residential* No ○ Yes ○ Unknown ○

*note this is different from Residential Care and Assisted Living

A. DEMOGRAPHICS

Personal Health # _____ Gender: _____ Marital Status: _____

Home Address _____

Phone # _____ Cell # _____

Best Person to Contact: _____ Phone #: _____

Home Address: _____

Relationship to the Client: _____

Other Contact People: _____

_____

_____

Primary Language Spoken: _____ Interpreter Required: No ○ Yes ○

Family Physician/ GP: _____ (last name, first name) Phone #: _____

FRASER HEALTH ACQUIRED BRAIN INJURY SERVICES (ABIS) REFERRAL FORM

B. INJURY INFORMATION

Type / Cause of Injury - check one

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

List details:

Is this injury the result of any of the following?

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

Please note that if any of the above are checked off, the client may not be eligible for services. Please contact the ABIS Intake Worker 604-520-4175 X 525390 or direct dial 604-528-5390 to discuss further.

If any of these situations apply - provide application status, file numbers, and contact information for involved individuals:

Is the Client involved in any litigation related to Brain Injury? Yes ◯ No ◯

Documented **Proof of Brain Injury -** indicate which are being sent with this application - only the documents listed below with * will be accepted as proof:

*CT Scan	☐	*Neurology Report	☐
*MRI Report	☐	*Physiatry Report	☐

Additional Reports and Supporting Documentation:

Occupational Therapy Report	☐	Physiotherapy	☐
Hospital or General Discharge Report	☐	Speech Language Therapy	☐

Please note that ABIS **may not be able to proceed** with the referral if required documented **proof** is not provided. If you require more information - please call 604-520-4175 X 525390, or direct dial 604-528-5390, or press 0, and ask to speak to an Intake worker.

C. SOCIAL ENVIRONMENT

Housing Situation - applies to current situation or just prior to hospitalization

Owns Home ☐
Rents Home ☐
Lives with Paid Caregiver ☐
Lives in Mental Health Resource ☐
Homeless ☐
Lives in a Facility ☐

Living Arrangements / Supports - applies to current situation or just prior to hospitalization

Lives with Spouse/Partner ☐
Lives with Family ☐
Lives with Roommates ☐
Lives with Children* ☐
Lives Alone ☐
*ages of any minor children ↘

Employment - this applies to the client's pre-injury employment status

Employed ☐
Retired ☐
Student ☐
Unemployed ☐
Stay at home parent ☐
List type of employment _____
Self-Employed ☐
Volunteer ☐

Legal Status - does the client have a Criminal History?

Yes* ◯ No ◯ Unknown ◯ * Complete Legal History Form (Appendix B)

***Please attach copies of all Legal Documents related to all Legal situations**

Do any of the following apply to the client's current situation?

	Yes*	No
Power of Attorney or Enduring Power of Attorney ← circle which one(s) apply	◯	◯
Representation Agreement - Section 7 or Section 9	◯	◯
Committee of Person and / or Finances -circle which one(s) apply	◯	◯
Public Guardian and Trustee Office Involvement	◯	◯
Mental Health Certification	◯	◯
Protection under the Adult Guardianship Act (Section 59)	◯	◯

*If the answer is **YES** to any of the above - please list details here:

D. FUNCTIONAL PROFILE

Cognitive Status - client has challenges with the following:

Memory ☐	Attention ☐	Poor Safety/Judgement ☐
Planning ☐	Motivation ☐	Following Through with Activities ☐
Confusion ☐	Impulsivity ☐	Starting Tasks (Initiation) ☐
Gets Lost Easily ☐	Problem Solving ☐	Lacks Insight or Awareness ☐
Visuospatial ☐	Perceptual ☐	Troubled by Noisy/Busy Environments ☐

Comments / Goals for Service / Safety Concerns:

Instrumental Activities of Daily Living Status (indicate level of care needed)

	Independent	Needs Cueing/ Supervision	Dependent
Self Care	○	○	○
Meal Prep	○	○	○
Bank/Shopping	○	○	○
Household Management (Bill Paying, Cleaning, Laundry):	○	○	○
Community access	○	○	○
Can the applicant use a phone	○	○	○

Can the applicant be left alone? No ☐ Yes* ☐ *How long can they be left (hrs)

Comments / Goals for Service / Safety Concerns:

Physical Status - client has challenges with the following:

Balance ☐	Gait / Ambulation ☐	Endurance /Activity tolerance ☐
Strength ☐	Transfers ☐	Vision or Hearing ☐
Tone ☐	Ataxia ☐	Range of Motion ☐

List equipment needs:

Comments / Goals for Service / Safety Concerns:

Speech and Language Status -client has challenges with the following:

Reading ☐	Expressive Language ☐	Communication Basis Needs ☐
Writing ☐	Understanding Speech ☐	Cognitive Communication ☐
Eating/drinking ☐	Word finding difficulties ☐	

Comments / Goals for Service / Safety Concerns:

E. HEALTH ISSUES

Mental Health (Suspected and /or Diagnosed):

Please specify condition(s), current status, and treating physician / psychiatrist and / or service:

Substance Use - Does the client have a current or past problem with substances?

Please explain - include current / past use:

Past Medical History and other relevant Medical Conditions

Please specify conditions (e.g. cardiac, cancer), current status, and treating physician or service:

F. INCOME INFORMATION

Are there any financial applications in progress? **Yes** ◯ **No** ◯

Are there any financial hardship concerns or does client need assistance in completing forms ? *** Yes** ◯ **No** ◯

* If the answer is yes, is the client interested in receiving assistance? **Yes** ◯ **No** ◯

Current Income: _____ Source of Income: _____

Please provide details or hardship or support required:

Some of ABI Services are income based or require a client co-payment. If ABIS Specialized Residential resources are being requested, this application must have attached proof of the client's current monthly income.

Please indicate which of the following is included with the application:

Employer Cheque Stub ☐ InterRai Financial Assessment Form ☐

Income Tax Notice of Assessment ☐ 3 months bank statements* ☐

*If the income is non-taxable then proof to demonstrate that needs to be provided

Other - please describe: _____

Current Monthly Taxable Income _____

G. REFERRING PERSON INFORMATION

Name and Title (if applicable) of person completing this referral:
Contact Information:
Relationship to Client:

Is the client aware of this referral? Yes ◯ No ◯

List all other services / programs that this client is involved with or referred to:

H. CONSENT

Is a signed consent form attached to this referral? Yes ◯ No* ◯

*If the answer is no - please explain:

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Appendix A - Client Authorization

Client's Name _____ Date of Birth _____
last name, first name d/m/yr

Address _____

Client's Phone # _____ PHN#: _____

Next of Kin or Caregiver _____

Next of Kin Phone # _____

Authorization for the Collection, Use and Disclosure of Information

☐ I hereby permit the Fraser Health Acquired Brain Injury Services to collect, use, and disclose personal information related to the above named client for the purposes of assessing eligibility, provision of services, and ongoing consultation with the following listed professionals and agencies: **Residential Providers, Community Social Service Agencies, Day Program Providers, Rehabilitation Service Providers, Police Agencies, Physicians.**

☐ **I hereby consent to receive services from Fraser Health Acquired Brain Injury Services.**

I have read and understood this consent form. Yes ☐ No ☐

_____ _____
Signature of Client or Legally Authorized Representative* Date (d/m/yr)

*In most cases, the client should sign this form. If another person signs, please attach a copy of the document assigning legal representation (this does not include Power of Attorney). Clients, or their legally authorized representatives, can revoke or alter this consent at any time and are encouraged to contact the Fraser Health Acquired Brain Injury Services if they wish to do so.

This consent will expire 90 days after the client is discharged from the program.

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Appendix B – Legal History Form

Has the applicant been previously arrested, charged, or convicted of any crime in Canada or outside of Canada?

YES* NO

*If the answer is yes, please provide the following:

List all charges/convictions:

Date and location of any sentences:

Is the applicant currently on probation? YES* ◯ NO ◯

*If the answer is yes, please provide the name of the Probation Officer:_____

Does the applicant have any outstanding charges, warrants, or court related hearings?

YES* ◯ NO ◯

If the answer is yes, please describe, noting charges, locations, dates of upcoming hearings, etc:

Neurobehavioral Inventory

Client Name: **Date:** **Rater Name:**

Client DOB: **CHECK THE APPROPRIATE BOX AND THE APPROPRIATE SUBCATEGORY**

1. Nutrition	needs to be fed	eats with assistance	eats with prompting	eats indenpendently
2. Bladder	Incontinent	continent if toileted	self-continent with prompt	self-continent - no prompt
3. Bowel	Incontinent & /or smears	continent if toileted	self-continent with prompt	self-continent - no prompt
4. Bathing/grooming	needs to be bathed or groomed	bathes/grooms with assistance	bathes/grooms self with prompt	bathes/grooms self-no prompt
5. Dressing	needs to be dressed	dresses with assistance	dresses self with prompt	dresses self without prompt
6. Mobility	bed/chair bound	mobile with wheelchair	mobile with walking aids	independantly mobile
7. Orientation	disoriented	oriented with written prompts	oriented with verbal prompts	oriented-no prompts
8. Spatial orientation	unable to locate bedroom	locates bedroom-sign needed	locates bedroom no sign needed	locates all rooms
9. Wanders	wanders; needs locked doors	wanders; needs closed doors	wanders but returns	no wandering
10. Social 1:1	mute and unresponsive	mute, but responsive	little verbal output	verbal and accessible
11. Social group	isolates	PISA* (XM) with prompt	PISA (XM) without prompt	spontaneously people seeking
12. Attention	GSA* 0-15 minutes	GSA 15-30 minutes	GSA 30-60 minutes	GSA >60 minutes
13. Screaming/yelling	constantly	frequently	occasionally	never
14. Motor restlessness CIRCLE the behavior/s that apply and then indicate the total that apply	3/3	2/3 *a. pacing*	1/3 *b.frequent changing p*ositions	0/3 *c. foot tapping and/or hand wringing*
15. Disinhibition CIRCLE the behavior/s that apply and then indicate the total that apply	3/3	2/3 *a. irritable, loud or silly*	1/3 *b. intrusive - verbal or interpersonal space*	0/3 c *inappropriate public habits*
16. Apathy CIRCLE the behavior/s that apply and then indicate the total that apply	3/3	2/3 *a.aimless/mindless laying & or sitting for hours*	1/3 *b. quiet*	0/3 *c. slow*
17. Aggressive behavior	**Date of Most recent Aggression:** _____ combative-unpredictable	combative-predictable	verbally threatening	no inappropriate aggression
	Frequency of aggression:	a. daily	b. 2-3 per week	c. 1 per week d. 1 per month e. 1 per 6 months
18. Sexual behavior	**Date of most recent episode:** _____ public self-play/display	private self play/display	inappropriate touching/remarks	no inappropriate behavior
	Frequency of sexual behavior:	a. daily	b. 2-3 per week	c. 1 per week d.1 per month e. 1 per 6 months
19. Compliance ADL's	refuses to participate in ADL's	* PIADL -strong prompt	PIADL-moderate prompt	PIADL/mild no prompt
20. Compliance treatment	refuses	strong prompts	moderate prompts	mild/no prompts

*PISA (XM) -participates in schedules activities (excluding meals)

*GSA - ability to sustain goal-directed activity in minutes

*PIADL = participates in activities of daily living

APPENDIX 1

NEUROBEHAVIORAL INVENTORY – REVISED 2004 (NBI-R)

INSTRUCTIONS

1. **Check the behaviors that best describe the patient such as in Questions 12, 14, and 16: these items may require the assessor to obtain the relevant data from caregivers who have spent sufficient time with the patient.**
2. **Abbreviations are explained below a specific question.**

3. **Questions 14, 15 and 16 are each broken down into 3 subcategory behaviors. CIRCLE the behavior/s that apply and then indicate the total that apply, e.g. 0/3, 1/3, 2/3 or 3/3.**

e.g. **MOTOR RESTLESSNESS** ☐ **3/3** ☑ **2/3** ☐ **1/3** ☐ **0/3**

a. pacing **b. frequent changing positions** **c. foot tapping &/or hand wringing**

4. **Questions 17 and 18: circle the frequency of the specified behavior and the date that an aggressive or sexual behavior last occurred.**

e.g. **AGGRESSIVE BEHAVIOR** ☐ **combative unpredictable** ☑ **combative predictable** ☐ **verbally threatening** ☐ **no inappropriate aggression**

Frequency of aggression ***a. daily*** ***b. 2-3/week*** ***c. 1/week*** ***d. 1/month*** ***e. 1/6 months***

Date of most recent episode ***3 July 2001***

5. **Behaviors: most are self-explanatory.**

   a. **Prompting means the patient needs coaxing and/or supervision.**

   b. **Disinhibition:**
      i. **irritable, loud and/or silly**
      ii. **intrusive, e.g. barges into personal space, nursing station, or office; verbally interruptive, lacking awareness of, or insensitive to, appropriate social cues.**
      iii. **Inappropriate public habits, e.g. voids, passes gas, picks nose in public.**

6. **Private self-play/display means the failure to stop sexual self-play/display when privacy is interrupted.**

T. A. Hurwitz