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| **A. Your Information** | | | | | |
| Last Name: | First Name: | | | | Preferred Name: |
| Date of Birth (dd/mm/yyyy): | Personal Health Number: | | | | Preferred Language: |
| Address: | City, Province: | | | | Postal Code: |
| Main Phone Number: | Alternative Phone Number: | | | | Email: |
| Other Person to Contact: | Relationship: | | | | Phone Number: |
| Primary Health Care Provider (Doctor, Nurse Practitioner): | | | Phone Number: | | |
| Pronouns:  He/His/Him  She/Her/Hers  They/Them/Theirs  Other, please specify | | | | | |
| Gender:  Male  Female  Non-Binary  Other, please specify | | | | | |
| Do you wish to identify as an Aboriginal / Indigenous person?  Yes  No  Prefer not to answer | | | | | |
| If **yes**, select **ALL** that apply:  First Nations  Inuit  Metis  Status Non-Status  Other, please specify | | | | | |
| Citizenship Status:  Canadian Citizen  Landed Immigrant  Sponsored Immigrant  Refugee Status  VISA Permit  Other, please specify | | | | | |
| **B. Who helped you with this referral?** | | | | | |
| Myself  Family/Friends  Doctor  Nurse Practitioner  Other | | | | | |
| Referring Person Name: | | Relationship: | | Phone Number: | |
| **C. About your brain injury** | | | | | |
| Date of Injury: | | | | | |
| Which hospital did you attend (if any)? | | | | | |
| Is this injury from:  Motor Vehicle Accident  Work-Related Injury  Victim of Crime  Other; please specify | | | | | |
| Type of Brain Injury:  Anoxia/Hypoxia (lack of oxygen)  Traumatic Brain Injury (bump, hit or jolt to the head)  Stroke  Tumour (Abnormal growth)  Infection  Other | | | | | |

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| **D. About you** |
| **Current living environment:**  Alone  With Family  With Friends  Other |
| **I am having trouble with the following daily activities:**  Getting around the community  Budgeting  Shopping  Taking a shower  Completing household duties  Paying Bills  Getting dressed  Going to the washroom  Speaking to others  Other |
| **I have the following support:** |
| **Is there anything else you would like us to know?** |