

Community Brain Injury Program for Children & Youth in British Columbia

Referral Form

Personal Information

Name: _____
LAST FIRST MIDDLE

Birth Date: _____ M _____ F _____ PH#: _____
YEAR/ MONTH/ DAY

Parent/Guardian(s): _____

Address: _____

POSTAL CODE

Telephone: _____
HOME WORK CELL

E-Mail Address: _____

Language Spoken: _____ Interpreter Needed: _____ Y _____ N
PRIMARY SECONDARY

Medical Information

Referring Facility: _____
CONTACT NAME PHONE NUMBER

Admission Date: _____ Anticipated Discharge Date: _____

Primary Community Physician: _____ Phone: _____

G. C. S.: _____

Diagnosis: _____

Comments: _____

• Documentation: Referrals must be accompanied by supporting documentation such as:

- › intake summaries, reports & progress notes
- › consultation reports (physician, therapist)
- › reports from preschools, schools, Infant Development Programs, etc.

I hereby give consent for referral to the BC Centre for Ability and give them permission to obtain pertinent information regarding my child.

Printed Name of Referring Person _____

Signature of Referring Person _____

Date _____

Signature (Parent/Guardian) _____

Date _____

Acute/Rehab Team Discharge Plan

It is necessary to obtain an overview of the acute/rehab Discharge Plan in order to facilitate the link-up of community resources. Please complete the following multidisciplinary overview ASAP and fax to Joshua Myers, Community Brain Injury Program at (604) 451-5651.

Name: _____

Date of Birth: _____

Facility: _____

Anticipated Date of Discharge: _____

Child / Family Needs	Services Required and Recommended Frequency	Suggested Referral / Phone #:

Completed By: _____ Date: _____