Community Brain Injury Program for Children & Youth in British Columbia

Referral Form

Personal Information

Name: _____
LAST FIRST MIDDLE

Birth Date: _____ M _____ F _____ _____
YEAR/ MONTH/ DAY PERSONAL HEALTH NUMBER

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: _____

Diagnosis: _____

Comments: _____

_____

- Documentation - Referrals **MUST** be accompanied by supporting documents such as:
  - › neurology summary, discharge summary, mental health consults
  - › specialist reports, therapist notes

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

Community Brain Injury Program for Children and Youth in BC
2805 Kingsway, Vancouver BC V5R 5H9 Telephone : 604.451.5511, or Toll-Free : 1.877.451.5511
Fax : 604.451.5651 www. mybrainonline.ca

BC Centre for Ability
Beyond challenges—the sky's the limit

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 as soon as possible and fax to 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

Completed By: _____ Date: _____

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