arbi Association for the Rehabilitation of the Brain Injured

WELLNESS SERVICES APPLICATION

Date:

REFERRAL SOURCE

- ☐ Self/Brain Injury Survivor
- ☐ Community Connect YYC Partners
- ☐ Continuing Care Facility
- ☐ Other: _____
- ☐ Family or Caregiver
- ☐ Southern Alberta Brain Injury Society (SABIS)
- ☐ Community Accessible Rehabilitation (CAR)

REFERRING PERSON

If you are completing this form on behalf of someone else, please provide your information below.

Name: _____ Relationship to Survivor/Caregiver: _____

Phone: _____ Email: _____

REQUIREMENTS

☑ The survivor or caregiver has consented to this referral

ELIGIBILITY CRITERIA FOR SURVIVORS

- 18+ years of age
- Diagnosed with a moderate to severe acquired brain injury or caregiver for someone with an acquired brain injury
- Physically stable as per physician evaluation
- Resides within the boundaries of the Calgary Region
- Has goals pertaining to caregiving for individuals with a brain injury or managing their own brain injury
- Medical documentation supports the diagnosis of a moderate to severe brain injury

EXCLUSION CRITERIA FOR SURVIVORS

- Active psychosis or hallucinations
- Complex trauma
- Active substance abuse or misuse
- High degree of cognitive difficulties
- High degree of auditory comprehension difficulties, without reliable yes/no communication
- Another mental health diagnosis that may preclude treatment at ARBI

APPLICANT INFORMATION

Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

SURVIVOR-SPECIFIC INFORMATION

Alberta Health Care #: _____

Calgary Transit Access: ☐ Yes ☐ No If yes, please provide the number: _____

Is the survivor their own guardian? ☐ Yes ☐ No

Guardian Name: _____ Relationship to Survivor: _____

Note: *In the event the survivor is not their own guardian, please provide a copy of the relevant legal document (enacted personal directive or guardianship) indicating who is.*

MEDICAL INFORMATION

Date of Brain Injury: _____

Type of Injury: ☐ Traumatic Brain Injury ☐ Stroke ☐ Anoxic Brain Injury ☐ Other: _____

Swallowing Precautions/Diet: ☐ No Concerns ☐ Soft Diet ☐ Thin Fluids ☐ Thickened Fluids

Allergies: _____

Transfers: ☐ Independent ☐ Supervision ☐ 1-person ☐ 2-person ☐ Mechanical Lift

Mobility Aids: ☐ None/Independent ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Walker
☐ Cane ☐ AFO ☐ Splint ☐ Brace

Has the applicant had any falls in the last six months? ☐ Yes ☐ No If yes, how many? _____

Please provide details of substance use, alcohol intake, and/or psychiatric condition(s):

Note: *Please provide the survivor's Medical Discharge Report or AHS Consent to Disclose Health, Substance and Mental Health Information*

SERVICE REQUESTED

- ☐ Supportive counselling
- ☐ Connections to valuable community resources (e.g., housing, food, financial assistance, etc.)
- ☐ Community Connect Program (social events for survivors and their support network)
- ☐ Psychosocial education (e.g., support groups for survivors and/or caregivers)
- ☐ External Referral (e.g., fair entry)
- ☐ Other: _____

Submit this completed application form to Intake@arbi.ca

After submitting the form, applicants will be contacted to discuss the next steps.