

**APPLICATION FOR SERVICE  
PEEL HALTON DUFFERIN ACQUIRED BRAIN INJURY SERVICES**

176 ROBERT SPECK PARKWAY  
MISSISSAUGA, ON L4Z 3G1  
Tel: (905) 949-4411 Fax: (905) 949-4019  
Email: intake@phabis.com  
Website: www.phabis.com

Client Name: \_\_\_\_\_  Male  Female  
(Last Name, First Name)

Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
                          year   month   day

**PERSONAL INFORMATION**

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Check One:  Single  Married  Divorced

Current Living Situation:  alone  with others (specify) \_\_\_\_\_

Accommodation:

- house  group home  apartment building  supportive housing  rooming house  
 long term care facility  hospital  other \_\_\_\_\_

Citizenship:  Canadian  Permanent Resident  Other

Are you a resident of Ontario?  Yes  No If yes, how long? \_\_\_\_\_

Language Spoken: \_\_\_\_\_ Interpreter Required:  Yes  No

First Nation Band Affiliation: \_\_\_\_\_

Status Number with Dept. of Indian Affairs: \_\_\_\_\_

**BRAIN INJURY INFORMATION**

Date of Injury: \_\_\_\_\_

Cause of Injury: (e.g. anoxia, assault, motor vehicle accident, fall, etc.) \_\_\_\_\_

**PERSONAL SUPPORT NETWORK /EMERGENCY CONTACTS**

**Emergency Contact Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**Other Contact Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**REFERRING AGENT (Person making the request):**

**Name:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Agency: \_\_\_\_\_ Email: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Person Yes No

**TYPE OF SERVICE REQUESTED**

Residential  Day Services  Outreach Services  Other:

**TREATMENT HISTORY INCLUDING CURRENT SERVICES**

Program/Facility/Hospital	Dates Involved (year/month/day)	Contact Name and Phone Number

**TREATMENT HISTORY CONTINUED**


**LIST OF SERVICES YOU HAVE APPLIED FOR FROM OTHER AGENCIES**

(e.g. Vocation Rehabilitation, Addiction Services)

Name of Facility / Program	Contact Person	Address, phone number	Status of Application

Please note that medical, attendant care, rehabilitation and vocational reports are required: Neurosurgery, Neuropsychology, Speech Therapy, Physiotherapy, Occupational Therapy, Social Work, Psychology, Psychiatry, Assessment and Discharge Summaries. If you have copies of these reports please attach to the application.

**PERSONAL INFORMATION**

Seizures  No  Yes

If yes, describe: \_\_\_\_\_

Wheelchair  No  Yes  Manual  Motorized

Transfers  Yes  No

If yes, describe: \_\_\_\_\_

Assistive Devices  No  Yes

If yes state what is needed: \_\_\_\_\_

Attendant Care  No  Yes

If yes, describe: \_\_\_\_\_

Supervision or assistance with walking  No  Yes

If yes, does it apply to:  level surfaces  stairs or  both

Communication Issues:  No  Yes

If yes, describe: \_\_\_\_\_

Other Physical Conditions (allergies, heart conditions, diet restrictions, etc)  No  Yes

If yes, describe: \_\_\_\_\_

Pre-Injury History of Substance Abuse:  No  Yes  history not available

Current Substance Abuse:  No  Yes  not known

Substance Abuse Treatment Recommended:  No  Yes

Previous Psychiatric History:  No  Yes

Describe: \_\_\_\_\_

Current Psychiatric Status: \_\_\_\_\_

Psychiatric Consult Notes:  included  report to follow  not available

Education: Highest grade/level attained: \_\_\_\_\_

If in school, name of school: \_\_\_\_\_

Name of Last Employer: \_\_\_\_\_

Position: \_\_\_\_\_ How long were you in this position? \_\_\_\_\_

**LIST OF MEDICATIONS**

**FINANCIAL INFORMATION**

**Check Source Of Income:**

- Ontario Disability Support Program (ODSP)
- Old Age Security (OAS)
- Workplace Safety Insurance Board (W.S.I.B.)
- Lawyer's Name: \_\_\_\_\_  
Company: \_\_\_\_\_ Phone: \_\_\_\_\_
- Insurance Adjuster Name: \_\_\_\_\_  
Company: \_\_\_\_\_ Phone: \_\_\_\_\_
- Rehabilitation Case Manager Name: \_\_\_\_\_  
Company: \_\_\_\_\_ Phone: \_\_\_\_\_

- Ontario Works (OW)
- Canadian Pension Plan (C.P.P.)
- Long Term Disability (private)
- Insurance Settlement
- Structured Settlement
- Inheritance
- Part Time Employment
- Full Time Employment
- Income Generating Assets - please describe: \_\_\_\_\_

Amount of income per month: \_\_\_\_\_

Do you have direct access to your income?  Yes  No **If no**, Name and Phone Number of Substitute Decision Maker/Power of Attorney and attach supporting documentation:

**Do you make your own personal decisions?**  Yes  No **If no**, Name and Phone Number of Substitute Decision Maker/Power of Attorney and attach supporting documentation:

I, \_\_\_\_\_ certify that the above mentioned information is correct, to the best of my knowledge.

### AUTHORIZATION TO SHARE INFORMATION WITH OTHER AGENCIES

I, \_\_\_\_\_, have completed or have had this Application for  
(Print Name)

Service completed for me. I give permission for the information contained herein to be shared with the agencies listed below in order to facilitate appropriate and timely service provision.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Legal Guardian/Committee Signature/  
Power of Attorney/Substitute Decision Maker  
(if applicable)

\_\_\_\_\_  
Please Print Applicant Name

\_\_\_\_\_  
Please Print Guardian / Committee Name  
Power of Attorney/Substitute Decision Maker  
(if applicable)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

<b>ONTARIO COMMUNITY BASED NON-PROFIT PROGRAMS FOR ADULTS WHO LIVE WITH THE EFFECTS OF BRAIN INJURY</b>			
<b>Program Name (Check off agencies you have made application to)</b>	<b>Address</b>	<b>Phone Number</b>	<b>Fax Number</b>
<input type="checkbox"/> Brain Injury Community Re-Entry (Niagara) Inc.	261 Martindale Rd., Units 12 & 13 St. Catharines, ON L2W 1A1	(905) 687-6788 1 800 996-8796	(905) 641-2785
<input type="checkbox"/> Brain Injury Services of Hamilton, Haldimand-Norfolk, Niagara	225 King William Street, Suite 508 Hamilton, ON L8R 1B1	(905) 523-8852	(905) 523-8211
<input type="checkbox"/> Brain Injury Services of Northern Ontario	426 Balmoral St. Thunder Bay, ON P7C 5G8	(807) 623-1188	(807) 623-1201
<input type="checkbox"/> Brain Injury Services of Muskoka Simcoe	560 Bryne Dr. Unit 4 Barrie, ON L4N 9P6	(705) 734-2178 Toll Free #: 877-320-1950	(705) 734-1598
<input type="checkbox"/> Community Head Injury Resource Services of Toronto (CHIRS)	62 Finch Avenue West Toronto, ON M2N 7G1	(416) 240-8000	(416) 240-1149
<input type="checkbox"/> Dale Brain Injury Services Inc.	815 Shelborne St. London, ON N5Z 4Z4	(519) 668-0023	(519) 668-6783
<input type="checkbox"/> Peel Halton Dufferin Acquired Brain Injury Services (PHD ABIS)	176 Robert Speck Parkway Mississauga, ON L4Z 3G1	(905) 949-4411	(905) 949-4019
<input type="checkbox"/> Vista Centre	211 Bronson Ave., Ste. 214 Ottawa, ON K1R 6H5	(613) 234-4747	(613) 234-3625

Revised March 17, 2009