PHYSICIAN REFERRAL

Date of Referral: ________________________
Name of Physician: ________________________

Personal Information				
Individual's Name (Last Name, First Name)			Date of Birth (mm/dd/yy)	Sex ❑ Male ❑ Female
Address	Apt. #		Home Phone Number:	
City	Prov.	Postal Code	Health Card Number:	

Brain Injury Information	
Date of Injury: ________________________ Diagnosis (ABI and/or other): ________________________	Cause of Injury (e.g. anoxia, assault, motor vehicle accident, fall, etc.):

Treatment History (including other services involved or referred to)

Do you have relevant collateral to assist with rehab planning for BISNO services: Yes ___ No ____
If yes, is this information included with the referral: Yes ___ No ____
Are you willing to make other referrals if required: Yes ___ No ____

Reason for Referral

Indicate the areas for assessment and rehabilitation strategies:

- ☐ **COGNITION (i.e. memory, attention, organization, problem-solving, time management**
- ☐ **DAILY LIVING SKILLS (i.e. budgeting, grocery shopping, household tasks)**
- ☐ **PSYCHOSOCIAL (i.e. communication, anger management, stress management)**
- ☐ **MEDICAL/PHYSICAL (i.e. accessing resources to address medical/physical needs or concerns)**
- ☐ **COMMUNITY PARTICIPATION (i.e. meaningful activities outside of the home)**
- ☐ **VOCATION/EDUCATION (i.e. strategies to use/prepare for return to work/studies)**
- ☐ **GROUPS (i.e. peer support, skill building)**
- ☐ **SERVICE COORDINATION (i.e. access/referrals)**

Physician Signature: ____________________________

Contact #: ____________________________

***BISNO's Intake Coordinator will arrange a meeting with the individual to complete the full application for service.**

BISNO – 426 Balmoral Street, Thunder Bay P7C 5G8 – (807) 623-1188 – Fax: (807) 623-1201