Brain Care Centre®
Defy Limitations!

Referral for Brain Care Centre (BCC) Services
Self-Referral Form

PART 1

Today's Date:

Month	Day	Year

Do you have **PDD (Persons with Developmental Disabilities)** funding?

☐ Yes — You are **not eligible** for BCC services

☐ No — **Continue**

Buchanan Centre – 11209 86 St. NW, Edmonton, Alberta T5B 3H7
Tel. (780) 477-7575 | Fax (780) 474-4415 | www.braincarecentre.com

About You

First Name	Last Name

Date of Birth:

Month	Day	Year

Personal Health Number:

					-					

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Where you live:

Address	
City	Province
Postal Code	
Group Home: ☐ Facility: ☐	

Have you ever worked with:

☐ ebirs Edmonton Brain Injury Relearning Society

☐ NABIS BRAIN INJURY SOCIETY

☐ Brain Care Centre® *Defy Limitations!*

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Contact Information:

Phone (Home)	Phone (Cell)
Email	
Special considerations: ☐ I **prefer** email ☐ I **work** full-time ☐ English as **second language** (ESL) ☐ **Communication difficulty** (e.g. aphasia)	

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Alternate Contact:

Name:

Relationship:

- ☐ Partner
- ☐ Mother
- ☐ Father
- ☐ Sister/Brother
- ☐ Son
- ☐ Daughter
- ☐ Friend
- ☐ Other: _____

Phone:

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PART 2

Alternative Decision-Maker (if applicable)

Guardian: ☐ Private ☐ Co-Decision Making ☐ Supported Decision Making ☐ Public	**Name:** **Phone:**

Trustee: ☐ Private ☐ Public	**Name:** **Phone:**

Other ☐ Power of Attorney ☐ Personal Directive	**Name:** **Phone:**

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PART 3

Acquired brain injury is **damage to the brain** which:

- Happens **after birth**
- **Does not** get worse over time

When was your brain injury?

Month	Day	Year

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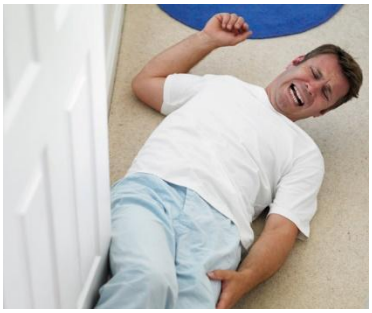
How did your brain injury happen?

☐ Assault

☐ Car accident

☐ Fall



☐ Sports

☐ Stroke

☐ Substance use

☐ Other: _____

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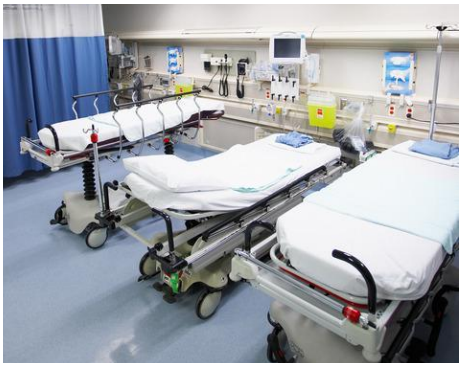
Severity of injury (please **check box**):

Hospital Information:



Hospital name:	**Date:**
Hospital name:	**Date:**

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Rehabilitation received:

Facility:	**Date:**
Facility:	**Date:**
Facility:	**Date:**

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What **services** do you have?

☐ Homecare

☐ Housing subsidy

☐ Financial assistance

☐ Transportation

☐ Other: _____

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Do you have **help** from:

☐ Family

☐ Friends

☐ Other:

_____

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Family Doctor	**Name:**	
	Phone:	**Fax:**
	Email:	

Other:	**Name:**	
	Phone:	**Fax:**
	Email:	

Other:	**Name:**	
	Phone:	**Fax:**
	Email:	

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Other **health concerns**:

☐ Diabetes

☐ Heart Condition

☐ Cancer

☐ Depression/Anxiety/PTSD

☐ Seizures/Epilepsy

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Do you have a **history** of:

☐ Substance use

☐ Violent behaviour

☐ Criminal charges

If any of the boxes are **checked:**

- **Further information** must be given
- Attach **documents** if needed

This information is collected to keep **staff, other clients, and yourself safe.**

I need **help** with:

☐ Housing

☐ Money

☐ Transportation

☐ Mental Health

☐ Living skills

☐ Social

☐ Support Group

☐ Device Help

☐ Leisure

☐ Other:

_____

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We require medical documentation of an **acquired brain injury**.

Example:

- Neuropsychological assessment
- Hospital discharge summary
- CT scan
- MRI scan
- Diagnosis from medical doctor

Please **choose one**:

☐ I have **attached** medical documents

☐ I **need help** getting medical documents

Hospital:

_____

OR Doctor:

_____

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Submit Your Referral

Choose **one:**

Mail 	Brain Care Centre 11209 86 Street NW, Edmonton AB, T5G 3H7
Fax 	780-474-4415 Attention: New Referral
Email 	info@braincarecentre.com

Referral form must be **completed**.

Incomplete referrals will be **sent back**.

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Referrals and medical documentation will be **kept for 1 year.**

If there is no contact, it will be destroyed.

By submitting this form, you **agree** that we may keep **confidential** and **secure** files with your information.