BRAINTRUST
CANADA

Referral Form
ABI Services

Referral Agency or Person: ________________________________ **Phone:** ______________________

Agency Contact/relationship: ____

Address: ____

Referral Date: ____

Please provide the following information in full.

Name(s):____

Address: ____

City:__________________________ Province: __________ Postal Code: ______________________

Phone number: ______________________ Email: ____

DOB: ______________________________Age: _______ Gender: _____________________________

BC Medical Number or PHN (if known):____

Date of suspected Injury: ____

Cause suspected of Injury: ____

Description of primary brain injury outcomes and any essential information about the person

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#100-215 Lawrence Avenue, Kelowna, BC V1Y 6L2 | PH 250-762-3233
FX 250-861-3008 | braintrustcanada.com

Emergency Contact (please include Relationship/Address/Phone number)

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____

____

Any medications/triggers/mental health concerns?

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Does the client have a relationship with substances or alcohol? (please describe)

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____

Are their any cultural/religious/identity considerations that the client wishes to be respected?

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Additional Notes:

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