# INITIAL CONTACT and REFERRAL FORM

Client Name: _____ Date of Referral: _____

Caller Name: _____ Phone: _____

Relationship to Client: _____

How did you hear about ABII? _____

## Client Information

Survivor _____ Other: _____

Age: _____ DOB: _____

Address: _____

Phone: (daytime) _____ (evening) _____

Family/Guardian Name: _____ Phone: _____

Date of acquired brain injury: _____

Cause:

- ☐ aneurysm
- ☐ anoxic
- ☐ blunt force trauma
- ☐ brain tumor(s)
- ☐ concussion
- ☐ drug / alcohol related
- ☐ infection (meningitis, encephalitis)
- ☐ motor vehicle collision
- ☐ stroke
- ☐ whiplash injury
- ☐ other _____

Details of injury:

## Reason(s) for referral

| SERVICE REQUESTED | URGENCY |
|---|---|
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| | |

Urgency Rating Scale:

| | |
|---|---|
| 3 (High) | Time sensitive (i.e. homeless within the week, close to foreclosure; unsafe living conditions; bankruptcy; Home Care discontinued) |
| 2 (Moderate) | Stable for now but requiring intervention (i.e. inappropriate housing, overdue bills; potential health risks) |
| 1 (Low) | Stable situation but intervention would improve independence (i.e. budgeting; transit training; organizational skills; community involvement; volunteering) |

Service Coordinator Name:

Scheduled Intake Date:

Intake Meeting Participants:

## Additional Comments

DATE

DATE

DATE: