DATE Y Y Y Y M M D D

Request for Service

Personal Information

Please attach a signed consent form authorizing the release of personal information to Community Solutions

FIRST NAME

LAST NAME

EMAIL ADDRESS

TELEPHONE

MOBILE

FAX NUMBER

DATE OF BIRTH Y Y Y Y / M M / D D

GENDER

AGE

PRIMARY LANGUAGE

MARITAL STATUS

ADDRESS

CITY

PROVINCE

POSTAL CODE

CURRENT LIVING SITUATION

IS THE INDIVIDUAL CURRENTLY IN HOSPITAL? ☐ YES ☐ NO

IF YES, WHICH HOSPITAL?

WHAT IS THE ESTIMATED DATE OF DISCHARGE (IF AVAILABLE)?

Y Y Y Y / M M / D D

IS THERE AUTHORIZED CONSENT FROM TREATING THERAPIST(S) IN HOSPITAL?

☐ NO ☐ YES — (if yes, please attach consent form)

Medical & Rehabilitation History

TYPE OF INJURY:

DATE OF INJURY Y Y Y Y M M D D

CAUSE OF INJURY:

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS:

CURRENT MEDICATION(S):

Request for Service

Medical & Rehabilitation History

Continued from previous page

HAS A CATASTROPHIC DESIGNATION BEEN DETERMINED? ☐ YES ☐ NO

DESCRIBE SEQUELAE OF THE INJURY. (Areas of strengths and weaknesses, medical status such as seizures, sleep disorders, etc.):

REHABILITATION/MEDICAL TEAM:

Identify area if applicable to the client

BEHAVIORAL ISSUES. Describe briefly and provide interventions (Verbal, physical aggression, sexual, etc.): ☐ Not Applicable

PSYCHIATRIC HISTORY. Describe briefly and provide current treatment (Depression, hallucinations, suicidal ideation): ☐ Not Applicable

LAW VIOLATIONS. Provide name of the lawyer and/or probation officer: ☐ Not Applicable

LEARNING DIFFICULTIES. Describe briefly and provide interventions (prior to injury): ☐ Not Applicable

Request for Service

Services Requested

Please include or attach to this referral current and/or relevant medical, rehabilitation reports (eg neuropsychological, occupational therapy, physiotherapy, speech & language)

Types of Services Requested

- ☐ COMMUNITY BASED ASSESSMENT
- ☐ IN-HOME COMMUNITY SUPPORT
- ☐ COTTAGE GETAWAY (1 WEEK, 2 WEEK, LONG WEEKEND)
- ☐ ACCESSIBLE TRAVEL SUPPORT
- ☐ SUPPORTED INDEPENDENT LIVING APARTMENT PROGRAM
- ☐ LONG TERM LIVING
- ☐ RESPITE CARE
- ☐ TRANSITIONAL LIVING
- ☐ PSYCHOSOCIAL/ EMOTIONAL SUPPORT
- ☐ BEHAVIOUR MANAGEMENT
- ☐ EDUCATIONAL SUPPORT AND/OR IN-CLASS SUPPORT
- ☐ SUPPORTED EMPLOYMENT
- ☐ OTHERS _____

ADDITIONAL DETAILS:

_____

_____

Type of Support Required (for above services)

- ☐ REHABILITATION ASSISTANT/SUPPORT WORKER
- ☐ COMMUNITY SUPPORT WORKER
- ☐ EDUCATION ASSISTANT
- ☐ JOB COACH
- ☐ PERSONAL SUPPORT WORKER/ATTENDANT
- ☐ COMPANION
- ☐ OTHERS (eg. Nurse) _____

SPECIAL STAFF SKILLS/CONSIDERATIONS:

_____

_____

Specific Time Requested

HOURS PER DAY	DAYS PER WEEK	LENGTH OF CONTRACT	START DATE
			Y Y Y Y / M M / D D

GOALS/ADDITIONAL COMMENTS:

_____

_____

Approval of Service by

1. APPROVAL HAS BEEN RECEIVED AND A COPY IS ATTACHED ☐ YES ☐ NO
2. TREATMENT PLAN (OCF-18) ☐ YES ☐ NO
   HAS APPROVAL BEEN RECEIVED? ☐ YES ☐ NO
   IF YES, PLEASE INCLUDE A COPY WITH THIS REQUEST FOR SERVICES.
   IF NO, DETAILS TO COMPLETE THE TREATMENT PLAN (OCF-18) ARE:
   REGULATED HEALTH PROFESSIONAL NAME: _____
   CONTACT INFORMATION: _____
   INJURY & SEQUELAE INFORMATION (ICD-10 CODES): _____
3. ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1) ☐ YES ☐ NO
4. NO CONTRACT IS REQUIRED ☐ YES ☐ NO
   (A Letter of Engagement will be prepared by Community Solutions Ltd.)

Request for Service

Funding Source

COMPANY NAME

ADDRESS

CONTACT PERSON

EMAIL ADDRESS

TELEPHONE NUMBER

FAX NUMBER

FILE NUMBER

CLAIM NUMBER

Legal Counsel

FIRM NAME

ADDRESS

CONTACT PERSON

EMAIL ADDRESS

TELEPHONE NUMBER

FAX NUMBER

Referring Agent

COMPANY NAME

ADDRESS

CONTACT PERSON

EMAIL ADDRESS

TELEPHONE NUMBER

FAX NUMBER

HAVE YOU CONTACTED COMMUNITY SOLUTIONS BEFORE? ☐ YES ☐ NO

Office Use Only (Please do not write in this section)

FOLLOW-UP:

STAFF ASSIGNMENT:

SUPERVISOR ASSIGNMENT: