Brain Injury Society
Education • Support • Housing

#2 – 996 Main Street, Penticton BC V2A 5E4
Tel: 250.490.0613 Fax: 250.490.3912
email: info@sosbis.com www.sosbis.com

REFERRAL FOR SERVICE

Acquired Brain Injury/Stroke

Name: _____ ❑ M ❑ F ❑ Transgendered

Address: _____ Telephone: _____

_____ D.O.B.: _____
yyyy/mm/dd

Referring Agency: _____ Telephone: _____

Name & Title: _____

Reason for referral:

_____

_____

Does the client have a physician or other specialist? If so, please indicate who and contact information:

_____

_____

Records of injury assessment available: ❑ Yes ❑ No *Please include relevant records

Cause and date of brain injury:

_____

_____

PRESENTING PROBLEMS:

Cognitive:	❑ Memory	**Physical:** ❑ Headaches	**Beh./Emotional:** ❑ Irritability
	❑ Decision Making	❑ Fatigue	❑ Apathy
	❑ Language	❑ Sleep	❑ Impulsively
	❑ Concentration	❑ Paralysis	❑ Depression and/or Anxiety
	❑ Other	❑ Other	❑ Other

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PSYCHIATRIC HISTORY: ❑ Yes ❑ No

Diagnosis: _____

Psychiatrist: ❑ Yes ❑ No Name: _____

Mental Health Case Manager: ❑ Yes ❑ No Name: _____

DRUG and/or ALCOHOL ABUSE: ❑ Yes ❑ No ❑ Previous ❑ Current

Other Service providers/agencies currently involved, specify:

_____

_____

Please indicate your commitment to ongoing involvement (check either or both):

❑ I am available for consult ❑ Please provide updates of progress

Signature: _____ **Date:** _____