
Brain Injury Relearning Services
856 Allowance Avenue SE
Medicine Hat, AB T1A 7S6

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# APPLICATION KIT

**PROGRAM APPLICATION – Brain Injury Relearning Services**

**Application completed by** _____ **Date** _____
(Self/Guardian)

Name _____ Phone# _____

Address _____ Postal Code _____

Street Address (if Different Than Mailing) _____

Date of Birth _____ Male/Female AHC# _____

Emergency Contact _____ Phone # _____

**Are you currently involved with an insurance Company?** YES NO
If **Yes**, Provide claim number and name of case worker

**Are you currently on AISH** YES NO
**If NO, have you applied?** YES NO **Do you plan to apply** YES NO

**Date of Injury** _____ **Cause of Injury** _____

**Diagnosis** _____

**How long were you in the hospital following your brain injury?**

**Name of Hospital** _____

**Physician's name** _____

**Address** _____ **Phone#** _____

**Are you presently taking any prescribed medication?** YES NO
If YES, please list

**Do you have Allergies?** YES NO
Please List

**Have you had seizures?** YES NO **Date of last seizure**
**Are your seizures:** Controlled (no Seizure for 6 months) ☐ Uncontrolled ☐

**Do you have any support needs we should be aware of? (i.e. you require assistance to use the washroom)**

_____

_____

**Are you currently receiving any of the following?**

| | **Physiotherapy** | **Occupational Therapy** | **Speech Therapy** |
|---|---|---|---|
| **Where?** | | | |
| **Name of Therapist?** | | | |

**Have you received any services from other agencies?** YES NO
If YES, which one(s)?

**Approximate dates of involvement** _____

**Have you had any neurological assessments?** YES NO

**When was the last test?** _____ **Conducted by?** _____

**Where did you receive the last test?** _____

**What level of education did you reach before injury?** _____

**What was your occupation before the injury?** _____

**Are you currently employed?** YES NO

**If yes, what do you do?** _____

**How many hours per week do you work?** _____

**What is your primary mode of transportation?** _____

**Have you ever been charged with a criminal offence?**
**Before the injury** YES NO
**After the injury** YES NO

**What are your main source(s) of income/funding?**

_____

**Do you have a:**

Power of Attorney Name _____ Phone# _____

Private Guardian Name _____ Phone# _____

Public Guardian Name _____ Phone# _____

Private Trustee Name _____ Phone# _____

Public Trustee Name _____ Phone# _____

**Living Arrangement**

- ☐ Alone
- ☐ Living with friend
- ☐ Living with family
- ☐ Group Home
- ☐ Approved home

Other _____

**Please check off activities that are difficult for you**

- ☐ Personal Hygiene
- ☐ Communication
- ☐ Home Living Skills
- ☐ Social/Emotional
- ☐ Memory
- ☐ Attention/Concentration

**How would you rate your life now, on a scale 1- 10**

1 2 3 4 5 6 7 8 9 10

**How did you hear about this program?**

**What would you like this program to do for you?** _____

_____

_____

**If you are accepted into the program for assessment, when can you start?**

_____