**Supports for Community Living**

**Brain Injury Assist Ltd.**

1914 -9th Avenue S.E.

Calgary, Alberta T2G 0V2

Phone: 403-261-8724 ext. 1 Fax: 403-261-8953

www.positivedevelopments.ca

**Referral/Application Form**

Our Supports for Community Living program (SCL) is a goal orientated program that addresses current challenges faced relating to Brain Injury.  Once goals are set, they will be reviewed every 6 months.

Our team offers support and strategies to help achieve goals and enhance independence. Participation in the achievement of goals is expected and a large part of success.

Applicants will be contacted to schedule an intake interview to further identify the fit of our program.   We have monthly drop-in sessions that can be attended in the meantime.  Applicants will be contacted with these details.

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| Individual with Brain Injury Information |  |
|  |  |
| Surname: | Name(s): |
| Date of Birth: | Preferred Pronouns: |
| Gender Identity: □ male □ female □ two spirit □ not-binary □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| AHC# | |
|  | |
| Address: | |
| City: | Postal Code: |
| Home Phone Number: | Alternate Phone Number(s): |
| Email Address: |  |
| Marital Status: | Emergency Contact: |
| Guardian or Trustee Name: | Guardian or Trustee Phone Number: |

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| History of Brain Injury |
| Date of Incident: |
| Type of Injury: |
| Incident Description: |
| If any additional background information is available (e.g. Neuropsychological Assessment, CAR discharge recommendations, etc.) *please attach to this referral* |

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| **Other Rehabilitation Services** OR currently receiving? | |
|  | |
| Name: | Date: |
|  |  |
|  |  |
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| **General Questions** |  |
| Do you currently smoke or vape? | Yes / No / Sometimes In home? Yes / No |
| Are there any pets in the home? Please identify |  |
| How many people live in the home? |  |
| Will there be visitors during our visits? | Who would they be? |
| What type of housing do you live in?  (Apartment, townhouse, house) |  |
| Parking considerations |  |
| Are there any dangerous weapons in the home? Please identify. |  |
| Are there any concerns with the safety of the home?  Such as unsafe area, parking, poor lighting, needles or drug paraphernalia? |  |

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| **Areas of Support** |
| List 3-5 potential goal ideas / areas of support that you would like assistance in achieving? These can also be further discussed during the intake interview. |
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| **Referral Source** | |
| Name: | Organization: |
| Contact number: | Date: |
| Email address: | |

**Referral Source will be contacted regarding post referral information.**

**Please fax completed referral to Michele Brooks at 403-261-8953 or email to:** [***brooksm@supportedlifestyles.com***](mailto:brooksm@supportedlifestyles.com)