Brain Injury Relearning Services
856 Allowance Avenue SE
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APPLICATION KIT

Revised July 2022

PROGRAM APPLICATION – Brain Injury Relearning Services

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

Name_____ **Phone #** _____

Address_____ **Postal Code**_____

City_____ **Email** _____

Date of Birth_____ **AHC #**_____

Please specify:

- **Male**
- **Female**
- **Non-Binary**
- **Two-Spirit**
- **Identity not listed**
- **Please tell us how you identify** _____

Emergency Contact_____ **Phone #** _____

Are you currently involved with an insurance Company? YES NO
If **Yes**, provide claim number, company name 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 #** _____

Have you had seizures? YES NO

Date of last seizure_____

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

Are you currently involved in 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 _____

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 is your main source(s) of income/funding?

_____

Do you have:

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? _____