51 Water St. Suite 205
Watertown, MA 02472
P: 617.744.8300
F:617.744.6018
www.brain-injury-rehab.com

"Together We Succeed"

Intake/Referral Line: 857.304.4028

Community Rehab Care est. 1996

COMMUNITY REHAB CARE – ABI/MFP WAIVER REFERRAL FORM

Thank you for your inquiry. To process this referral, we need to have the following information **completed PRIOR** to determining if this client is an appropriate candidate for outpatient services at Community Rehab Care (CRC).

Date: _____ Person completing form & title: _____

SERVICES REQUESTED AND FREQUENCY:

☐ **Physical Therapy** **Frequency:** _____	☐ **Occupational Therapy** **Frequency:** _____
☐ **Speech Therapy** **Frequency:** _____	☐ **ISCH:** **Frequency/hours per week:** _____

CLIENT INFORMATION:

Client Name: _____ **Date of Birth:** _____

Address: _____ **Home Phone #:** _____

Email: _____ **Cell Phone#:** _____

DIAGNOSIS (Select the primary):

☐ Traumatic Brain Injury ☐ Stroke ☐ Anoxic ☐ Tumor ☐ Neurodegenerative (i.e. Parkinson's, MS) ☐ Orthopedic ☐ Spinal Cord Injury ☐ Other: _____

ADDITIONAL CONTACT INFORMATION:

Guardian (if applicable): _____	**Phone #:** _____
Emergency Contact & Relationship: _____	**Phone #:** _____

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House Manager:_____	**Phone #:** _____ **Email:** _____
Waiver Service Coordinator:_____	**Phone #:** _____ **Email:** _____

PRIMARY CARE PHYSICIAN (PCP) & HEALTH INSURANCE INFORMATION:

PCP:_____	**Phone #:** _____
Address:_____	**Fax #:** _____
Health Insurance:_____	**Policy #:** _____

MEDICAL INFORMATION:

Please complete attached: **ABI/MFP Waiver Medical Intake Form**

OTHER:

1. Is the client receiving any other waiver-based services? Be specific (i.e., ADHP, in home therapies, ISCH. etc.) If yes, please list services and agencies providing as well as days/times of service delivery

   _____

2. What available days and times if this client available for in clinic and/or telehealth-based services:

   _____

3. How will the client be transported to and from the clinic?

   _____

4. Can the client access telehealth? (We are administering telehealth services via ZOOM)

   _____

5. Will a house staff member be available to assist the client during therapy sessions?

   _____

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OUTPATIENT READINESS QUESTIONAIRE:

1. Can this client tolerate 1-2 hours in a dynamic community setting?	Yes ☐	No ☐
2. Is this client able to manage toileting independently and/or with house staff support?	Yes ☐	No ☐
3. Does this client have specific and targeted goals for outpatient therapy?	Yes ☐	No ☐
4. Is this client motivated to attend identified services at an outpatient level of care?	Yes ☐	No ☐
5. Is this client able to transfer or stand with a 1 person assist? (non SCI related, PT specific)	Yes ☐	No ☐
6. Are the services being requested UNIQUE to the outpatient setting (i.e. home care is not addressing or able to provide) and require skilled therapist oversight?	Yes ☐	No ☐
7. Is the client open to small pairs and/or group therapy programming/wellness programming?	Yes ☐	No ☐

Please use this form to support reason for referral to CRC services. It is imperative that this form be filled out completely. Once all information is obtained, we will be in touch to schedule an evaluation and/or follow up with considerations.

Please feel free to call, fax, or email me as we work through this process together.

Tamara Torres, Referral Coordinator

Phone: 857-304-4028

Fax: 617-744-6218

Email: ttorres@brain-injury-rehab.com