SPINAL CORD INJURY ONTARIO
LÉSIONS MÉDULLAIRES ONTARIO

1-877-422-1112
Fax: 1-877-344-9962
referrals@sciontario.org

Client Services Referral Form (If possible, please complete form electronically)

Client Information

*Referral Date: dd/mm/yyyy		
*Last Name:	*First Name:	
Preferred Name:	*DOB:	Gender:
Health Card #:	Version Code:	Exp Date:
Address:		City:
Suite/Unit Number:	Postal Code:	Province:
Phone #: / Cell #:	Email:	
Primary Language:	Translator Requested: Yes ☐ No ☐	
Alternate Contact & Relationship:	Phone #:	

Referral Information (Please fill out as much as possible)

Self-Referral: ☐	** Only 1 referral option should be chosen (Self, Community, or Health Care Facility) **	
Community Referral: ☐	Facility/Agency:	
Health Care Facility: ☐	Facility/Agency:	Unit and Room Number:
Admission Date: dd/mm/yyyy	Discharge Date: dd/mm/yyyy	
*Referred By:	*Contact #:	
Is this referral for the family member of someone with an SCI: Yes ☐ No ☐		

Client Disability (Please fill out as much as possible)

Spinal Cord Injury (SCI): ☐ Non-SCI: ☐	Complete SCI: ☐ Incomplete SCI: ☐	Date of Onset:
Cause: Please choose from below		SCI Level:
Traumatic: ☐ Non-Traumatic ☐	Details of Diagnosis:	
Other Health Conditions:		

Referral Assessment (Please fill out as much as possible)

Is Insurance or WSIB Involved in your case: Insurance ☐ WSIB ☐ None ☐ Unsure ☐

Do you have a home/housing to return to? Yes ☐ No ☐	Is your home/housing accessible: Yes ☐ No ☐ Unsure ☐
Do you live/Will you be living alone? Yes ☐ No ☐	Will you require support services? Yes ☐ No ☐ Unsure ☐
Are you currently employed: Yes ☐ No ☐	Source of Income: ODSP ☐ CPP ☐ EI ☐ OW ☐ Unknown ☐ Other:_____

Are you working with any community agencies: Yes ☐ No ☐ Unsure ☐

Mobility Devices/Information Technology:

☐ None ☐ Cane ☐ Walker ☐ Manual Chair
☐ Power Chair ☐ Scooter ☐ Laptop/Tablet ☐ Talk to Text
☐ Smart Phone ☐ Unknown ☐ Other:

Are you interested in meeting/talking with someone from Peer Support? Yes ☐ No ☐

Are you interested in working with someone to access resources in your community: Yes ☐ No ☐

Are you looking only for more information at this time? Information only please ☐

What are the reason(s) for your referral to Spinal Cord Injury Ontario?

☐ By checking this box and providing my email and home address above, I/The client agree to receive information from Spinal Cord Injury Ontario. We respect your privacy and you can unsubscribe at any time.

☐ *I/The Client consent(s) to this referral being made to Spinal Cord Injury Ontario's programs and services

Please note a post discharge follow up call may be made by SCI Ontario.

Spinal Cord Injury Ontario respects your privacy. We protect your personal information and adhere to all legislative requirements with respect to protecting privacy. We will not rent, sell or trade your personal information. The information you provide to us will be used to deliver services and to keep you informed and up-to-date on the activities of Spinal Cord Injury Ontario. The information we collect from you is protected under the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Protection Act (PHIPA).

Please send your referral form to: referrals@sciontario.org

Please note, mandatory fields are outlined in red and marked with an *