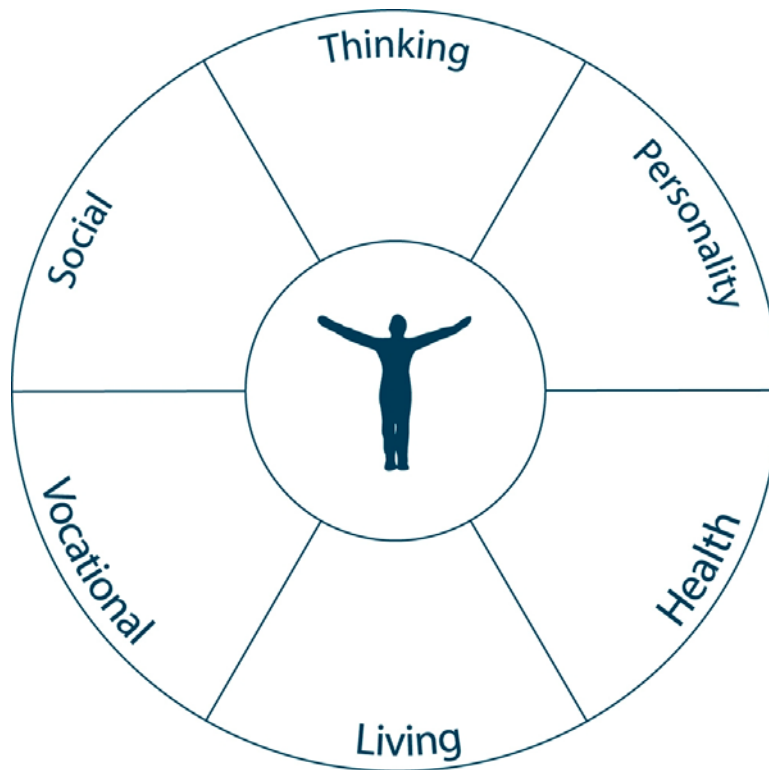


# Community Transitions

Brain Injury Rehabilitation Services for the Whole Person

[www.brainrehab.org](http://www.brainrehab.org)



# **Community Transitions Application Packet**

**Brain injury Rehabilitation  
For the Whole Person**

## **Admission Considerations**

We are pleased to offer a comprehensive brain injury rehabilitation program to meet your needs and help you reestablish an independent life. We look forward to helping you reach this goal. In doing so, we will be considering some criteria as you apply to the program.

We ask that you are able to meet your own personal/physical needs without total assistance. This includes eating, dressing and personal hygiene, the ability to move about independently by walking or using a wheelchair, and having no medical condition that requires skilled nursing care. We also ask that at the time of admission and for the duration of the program no alcohol or drug abuse occurs. For your protection and that of the other individuals we serve, there is no evidence of physically harmful behavior.

One final consideration is that you have a relative or friend willing and able to help support you and work with us throughout the program. We believe that your rehabilitation is a process that should involve loved ones, such as a spouse, children, parents, close relatives, and friends. These people are an important part of your recovery and rehabilitation. We encourage and look forward to the assistance of these important people.

If you have any questions regarding the application process or if you have concerns about any of the admissions considerations, please contact Ron Sasso, our Director, at (605) 718-8446 for more information and clarification.

We look forward to working with you and becoming a part of your future achievements.

<b>Community Transitions</b> <b>Application for Brain Injury Rehabilitation</b>
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GENERAL INFORMATION		
Legal Name (First)	(Middle)	(Last)
Current Address:		Phone #
City	State	Zip
Social Security Number:		Date of Birth
Sex	Height	Weight
Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____		
LEGAL INFORMATION		
Is applicant a minor or been declared incompetent by a judge? Yes _____ No _____		
Legal Guardian: <i>(Please attach copies of guardianship papers if applicable)</i> Name:		
Current Address:		Phone #
City	State	ZIP
Does Applicant have any prior legal convictions? Yes _____ No _____ If yes, felony or misdemeanor? Most serious charges:		
MEDICAL		
List known allergies:		
Any medical problems prior to injury? Describe:		
Cause of brain injury:	Date of brain injury:	Age at injury:
Dates of other head injuries and cause of injury:		
Does the applicant have seizures? Yes _____ No _____ Type of Seizures:		
Other Medical Concerns:		

Does applicant currently operate a motor vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_

Did applicant consume alcohol and/or non-prescription drugs prior to injury?

Yes \_\_\_\_\_ No \_\_\_\_\_ If so, what type and how often?

### CURRENT PRESCRIPTION MEDICATIONS

Name of Medication	Dosage and Frequency	Prescribing Doctor
Current Primary Physician:		Date of last exam
Address		Phone #
City	ST	ZIP

### FAMILY

Name of Spouse		Married how long?
Children of Applicant:		
NAME	AGE	GENDER

### EDUCATION

Highest Grade Completed: \_\_\_\_\_ H.S. Diploma or GED: \_\_\_\_\_

Was applicant in any special classes? Yes \_\_\_\_\_ No \_\_\_\_\_

Other Degrees or Diplomas Earned:

Best Subjects:

Worst Subjects:

Colleges/Trade Schools Attended:

**VOCATIONAL**

Name of Most Recent or Current Employer:

Dates of Employment:

Address:

Job Responsibilities:

Reason for Leaving (if applicable):

Wage:

Most significant former Employment:

Dates of Employment:

Address:

Job Responsibilities:

Reason for Leaving:

Wage:

**MILITARY SERVICES**

Have you served in any of the US military branches? Yes \_\_\_\_\_ No \_\_\_\_\_

Branch \_\_\_\_\_

Are you eligible for VA benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

**FINANCIAL INFORMATION**

Have you applied for Social Security Benefits? Yes \_\_\_\_\_ No \_\_\_\_\_ Result: \_\_\_\_\_

Social Security Amount: \_\_\_\_\_ SSI Amount: \_\_\_\_\_

Other Source of Income: \_\_\_\_\_ Amount: \_\_\_\_\_

**INSURANCE INFORMATION**

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Private Health Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_ (If "Yes," please list below):

(Company)

(Address)

(Policy Number)

**PERSONALITY**

Circle all the words below that describe the applicant BEFORE THE INJURY	Circle all the words below that describe the applicant SINCE THE INJURY	Comments:
Happy	Happy	
Depressed	Depressed	
Impulsive	Impulsive	
Self-controlled	Self-controlled	
Meticulous	Meticulous	
Neglectful	Neglectful	
Strong-Willed	Strong-Willed	
Apathetic	Apathetic	
Out-going	Out-going	
Shy	Shy	
Cooperative	Cooperative	
Uncooperative	Uncooperative	
Anxious	Anxious	
Calm	Calm	
Sexually Aggressive	Sexually Aggressive	
Physically Aggressive	Physically Aggressive	
Patient	Patient	
Impatient	Impatient	
Other:	Other:	
What is most frustrating for the applicant to deal with since the injury?		
Applicant's desired outcome of treatment?		
Applicant's life goals?		

**IN CASE OF EMERGENCY**

<i>Name</i>		Home Phone
Address		Work Phone
City	ST	ZIP
<i>Name</i>		Home Phone
Address		Work Phone
City	ST	ZIP

**This form must be completed and signed by a licensed physician.**

Applicant Name: \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_

**HAS THE PATIENT SUFFERED FROM ANY OF THE FOLLOWING: (PLACE X)**

____ Frequent headaches	____ Hemorrhoids	____ Burning on urination
____ Difficulty with vision	____ Fainting	____ Blood in urine
____ Difficulty with hearing	____ Chest pain	____ Excessive fatigue
____ Asthma/hay fever	____ Unusual weight loss/gain	____ Shortness of breath
____ Persistent cough	____ Cough producing blood	____ Unusual irritability
____ Swollen ankles	____ Loss of appetite	____ Frequent indigestion
____ Varicose veins	____ Diarrhea/constipation	____ Ulcers
____ Hernia (Rupture)	____ Accidents (Describe)	____ Fractures (Describe)
____ Other (Describe)	____ Operations (Describe)	____ Seizures

Describe:

If seizures, are seizures controlled? Yes No Frequency \_\_\_\_\_ Type \_\_\_\_\_

**PHYSICAL EXAMINATION: PLEASE CHECK ITEMS THAT WERE EXAMINED AND FOUND TO BE NORMAL. DESCRIBE ABNORMAL FINDINGS.**

Height (w/o shoes)	Weight	Temperature	F
Blood Pressure	Pulse	Respirations	
Eyes: R L	Nose:	Throat:	
Ears: R L	Mouth:	Neck:	
Lungs: R L	Heart:	Abdomen:	
Pelvic: Prostrate:	Feet:	Lab: CBC	_____
Pre-Admission TB results:	Date:	CCB	_____
Pre-Admission HEP B screening results:	Date:	PAP	_____
		Thyroid	_____
		UA	_____
		Blood Sugar	_____

Orthopedic Impairment: (Describe)

Physical Activities: Normal \_\_\_\_\_ Limited \_\_\_\_\_ (Explain)  
Exercise Program: Walking or Treadmill \_\_\_\_\_ Times per week \_\_\_\_\_ Minutes \_\_\_\_\_

Work and/or activities to be avoided:

Current Diet:

Changes:

Allergies:

**CURRENT PRESCRIPTION MEDICATIONS**

Name of Medication	Dosage and Frequency	Prescribing Doctor

May patient self-administer medications with supervision? Yes No

**WHICH OF THESE OVER THE COUNTER MEDICATIONS  
MAY THE CLIENT TAKE PRN PER PACKAGE INSTRUCTIONS?**

Yes No Acetaminophen	Yes No Cepastat lozenges	Yes No Sun Screen
Yes No Ibuprofen	Yes No Bacitracin Oint	Yes No Midol
Yes No Pepto-Bismol	Yes No Hydrocortisone Cr	Yes No M.O.M.
Yes No Maalox	Yes No Debrox Eardrops	Yes No Sudafed
Yes No Tums	Yes No Calamine lotion	Yes No Benadryl
Yes No Kaopectate	Yes No Tinactin cr/pwdr	Yes No Cough Drops
	Yes No Robitussin Syrup	

Does this individual have a Brain Injury? Yes No

Comment:

Is this individual medically stable? Yes No

Comment:

Does this individual need daily nursing services? Yes No

Comment:

Is the disability likely to continue indefinitely? Yes No

Comment:

Physician Signature

Date

Print Name

Phone #

Address:

City

State

ZIP