Synapse House
Admission Form 2.01.04A

Referral Date:		Referred by:			
Initial Contact:		Date of Tour:			
Last Name:		First:			
Address:					
City:	State:	Zip:	County:		
Home Phone:		Cell:			
Email Address:					
Date of Birth:	Date of Injury:		Gender:		
Marital status:	Single	Married	Divorced	Widowed	Separated
African-American American Indian Asian	Asian Indian Filipino Hispanic	Native Hawaiian White Mixed ethnicity			

Legal Guardian:	
Contact Info:	

Case #:	
Worker's Comp Case Manager:	
Contact Info:	
Brain Injury Medicaid Waiver Case Manager:	
Contact Info:	
DRS Vocational Case Manager:	Open Case?
Contact Info:	DRS Office:
Veteran's Case Manager or Vocational Counselor:	
Contact Info:	
Paratransit #:	Reduced Fare Card?

Are you receiving or using any of the following benefits?

SNAP (the Supplemental Nutrition Assistance Program) or Food Stamps?	
Medicare (Federally administered health insurance for elderly and disabled)?	
SSI (Supplemental Security Income)?	Amount: $
SSDI (Social Security Disability Insurance)?	Amount: $
Medicaid (Medical Insurance for Poverty level income recipients)?	
Section 8 or Housing Subsidies through Housing and Urban Development (Federally administered rent vouchers for people on or below poverty level income)?	
HBWD (Health Benefits for Workers w/ Disabilities, Medicaid purchased monthly premiums)?	

What are the reasons you are seeking services?

	Improve skills at life skills at home		Improve work skills / return to work
	Improve skills in community		Family needs (i.e. respite, day care)
	Improve social network		Improve life satisfaction

How much assistance do you need?

	All day		Only in the community
	At times		Minimal to none

What type of brain injury did you have?

	Traumatic injury		Infection, meningitis, encephalitis
	Stroke or aneurysm		Drug or alcohol overdose or abuse
	Epilepsy		Progressive disease
	Hypoxia - Lack of oxygen, cardiac arrest, drowning, carbon monoxide, respiratory		

Type of traumatic injury

	Motor vehicle		Violence		Military action
	Pedestrian hit		Bicycle		Work related
	Fall		Gunshot wound		

FOR EMPLOYMENT PROGRAM ONLY NON-BRAIN INJURY PARTICIPANTS

Please indicate your diagnosis for receiving services:________________________________

____

What are your interests and talents?____

____

What other medical conditions do you have? Check all that apply.

	Diabetes		Kidney disease
	High blood pressure		Cardiac issues
	Arthritis		Muscular-skeletal problems
	Stomach (ulcers, reflux)		Autoimmune disease
	Seizure disorder		Mental health
	Respiratory problems		Cancer
	Obesity		High cholesterol
	Swallowing problems		Substance abuse

If you have seizures, please describe what the seizure looks like and if you have any triggers (i.e. heat). ____

____

What assistance do you need after your seizure?____________________________________

____

What is your primary mode of transportation?

	Drive self		Walk
	Public transportation (bus, train)		Rides from others
	Para-transit services		Bicycle

How has the injury affected you? Check all that apply

	PHYSICAL ISSUES		COGNITIVE ISSUES
	Difficulty with walking		Slower processing speed
	Balance		Memory loss
	Paralysis or weakness – what side?		Difficulty initiating tasks
	Poor endurance		Reduced attention
	Trouble sitting down or standing up		Wandering or getting lost
	Trouble pushing the wheelchair		SPEECH & LANGUAGE ISSUES
	Tremors		Difficulty following directions
	Frequent falls		Problems with speaking
	Problems with vision		Aphasia or word finding problems
	Hearing loss		Difficulty reading
	Difficulty with dressing, grooming		Difficulty writing
	Difficulty with toileting or personal care		EMOTIONAL ISSUES
	Difficulty with taking medications		Cry easily / emotional
	Trouble getting in and out of a car		Easily frustrated
	Wears gait belt now		Use of alcohol or drugs to cope
	Uses walker or cane		Easily angered
	Has special glasses		Feelings of depression
	Uses service animal		Sometimes striking out or hitting

Describe in greater detail if you have checked any boxes above that relate to behavior, substance use, or psychological issues (i.e. what triggers the issue, any treatments)

Community Integration Questionnaire

Yes	No	
		Has your life changed regarding friendships?
		Has your life changed regarding romantic relationships?
		Has your life changed with regard to family roles?
		Has your living situation changed?
		Are you satisfied with your social network?
		Are you satisfied with your leisure or recreational activities?
		Do you have a primary care physician?
		Have you had a physical exam in the last 12 months?
		Do you have a dentist?
		Have you had a dental exam in the last 12 months?
		For women – have you had a recent mammography?
		For women – have you had a gynecological exam in the last 12 months?

With whom do you reside?

	Self		Children		Roommate
	Parents or siblings		Caregiver		Residential setting
	Spouse / significant other				

What is your current place of residence?

	House or apartment		Assisted living		Nursing home
	Treatment Program		Shelter		Homeless

Which of the following degrees have you completed? Major:

	Grade school		Associate Degree (2 yrs)
	High school or GED		Bachelor's Degree
	Technical Training		Master's degree
	Some College		Doctorate or professional degree

Yes	No	Career prior to injury?
		Are you currently employed? List job:
		Do you perform the same job you had prior to your injury?
		Do you volunteer? List site:

What other services are you receiving?
What are your overall goals that you would like addressed?

It is helpful if we can communicate with other services providers. If this is possible, please ask for a Release of Information form.

Thank you!