



# Brain Injury Association of Montana Referral Form

Fax completed form to: Resource Facilitation (406) 541- 4360

## Authorization to Participate in Resource Facilitation

**Patients Name:** \_\_\_\_\_ **Date of Discharge:** \_\_\_\_\_

I give permission to forward my name, address, and telephone number to the Brain Injury Association of Montana in order to be enrolled in their Resource Facilitation program.

Date of Birth: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

**Race (please circle):**

African American Asian Pacific Caucasian/Non-Hispanic Hispanic/Latino Native American Other

Date of Injury: \_\_\_\_\_

Cause of Injury: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Address: \_\_\_\_\_

Family Member/Significant Other or Guardian of Patient: \_\_\_\_\_

Address if different than patient: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

The Resource Facilitation Service **DOES NOT REPLACE** any medical or rehabilitation services that you may need. It is intended to provide you and your family with information about brain injury and assist in accessing services. The follow-up service is a FREE 24 month telephone based service. You can discontinue this follow-up service at anytime. This form grants BIAMT permission to use the categorical data (date of injury, cause of injury, race, gender) in data collection pertaining to brain injury in Montana.

Nurse/Discharge Planner/Social Worker: \_\_\_\_\_ Contact #: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

\* The BIAMT is dedicated to providing education, support, advocacy, resources and referrals for individuals with brain injuries and their families but does not provide medical diagnosis or advice.