



Brain Injury Alliance
M O N T A N A

Brain Injury Help Line Enrollment Form

Please Fax to BIAMT/BIHL at **(406) 541-4360**

1280 S. 3rd Street, Ste. 4, Missoula, MT 59801

1-800-241-6442

To create a better future for those impacted by brain injury through awareness, support, advocacy, community engagement, and the prevention of brain injury.

Participant / Patient Name: _____

Discharge Date (if applicable): _____

Date of Birth: _____		Language Spoken: _____	
Race: <input type="checkbox"/> African American	<input type="checkbox"/> Asian Pacific	<input type="checkbox"/> Caucasian/Non-Hispanic	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Native American	<input type="checkbox"/> Other _____	
Date of Injury: _____		Cause of Injury: _____	
Email: _____			
Telephone: (____) _____		Other: (____) _____	
Address: _____			
(Street address)	(City)	(State)	(Zip code)

Family Member/Significant Other or Guardian of Patient: _____	
Address (if different than above): _____	
Relationship to patient: _____	Email: _____
Telephone: (____) _____	Work: (____) _____

I hereby give permission to share the following information with the Brain Injury Alliance of Montana to be enrolled in the Brain Injury Help Line; a FREE 24 month telephone based support service.

Signature: _____ **Date** _____

The Brain Injury Help Line **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. 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, and gender) in data collection pertaining to brain injury in Montana.

Individual Making Referral: _____ Title: _____

Referring Agency: _____ Contact #: _____