HEAD INJURY REHABILITATION AND REFERRAL SERVICES, INC.
11 TAFT COURT SUITE #100
ROCKVILLE, MD 20850
(301) 309-2228
Fax: (301) 309-2278
E-Mail: hbi@headinjury.org

APPLICATION FOR SERVICES

Name:		Date:	
Address:		County:	
City, State, Zip:		SSN:	
Phone Numbers:			
Live With (Relationship):			
Marital Status:		DOB:	
Legal Guardian:			
Insurance Co.:		Policy #:	
Address, Phone, Contact Person:		Group #:	
Workers Comp. Co.		Claim #:	
Address, Phone, Contact Person:			
Medicaid, Medicare Policy Number:			
Income Per Month:		Source:	

Services Requested:	9 Cognitive Retraining	9 Vocational/Supported Employment
	9 Residential Services	9 Individual Support Services
	9 Neuropsych. Services	9 Other (Specify):
Referral Source (Name, Relationship, Address, Phone):		

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HISTORY OF INJURY:

Date of Onset:		Age at Onset:	
How Injury Occurred:		Hospital Where Initially Treated:	
Duration of Coma:		Hospital Dsg. Date:	
Rehabilitation:			
Course Following Rehabilitation			
Residual Effects:			
Emotional or Behavioral Changes:			
Psychotherapist, Address, Phone #			
Previous Evaluations Completed and Source			

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BACKGROUND INFORMATION:

Education:	
Vocational History:	
Previous Household Responsibilities:	
Pre-Morbid Personality, Interests:	

MEDICAL INFORMATION:

Physician Names, Addresses, Phones:			
Seizures (Type and Frequency):		Date of Last Seizure:	
Allergies:			
Special Dietary Needs:			
Mobility, Ability to Use Public Transportation:			
History of Alcohol or Substance Abuse:		Treatment:	

Form Completed By (Name and Title):	

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